

COMMUNITY INFLUENCES ON CANCER SCREENING
BEHAVIORS AMONG MEXICAN IMMIGRANT WOMEN

BY

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THESIS

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Abstract

Traditionally, Latina immigrants have suffered a disproportionate burden of breast and cervical cancer due to lower mammography and Pap smear screening participation. However, a study of the screening rates of Mexican immigrants living in a Chicago neighborhood revealed that not all immigrant communities exhibit low participation rates. The purpose of this two-phase, mixed-method study was to examine the social context in Little Village (LV) that contributes to women's high cancer screening rates. In the first phase of the study, I examined the knowledge, beliefs, attitudes and emotions of 41 Mexican immigrant women regarding breast and cervical cancer (including etiology, symptoms, and prognosis) as well as their screening practices. This quantitative phase revealed that despite having socio-demographic factors placing them at high risk of underutilizing screening services, such as immigrant status, low income, and low levels of formal education, women in LV reported high mammography and Pap smear screening rates, 87% and 95% respectively. In the second phase of the study, I examined the role of place and its influence on screening behaviors. In-depth interviews with six organization and three community representatives revealed that medical, faith-based, and community institutions in LV mitigate barriers related to language access and awareness of resources, which enhance accessibility to screening exams and services. Despite this, some women in LV still face significant barriers to screening adherence such as misinformation about breast and cervical cancer and screening exams. Given the multiple determinants of health behavior and that several known predictors of screening such as access to services and information about early detection are place based, I argue that social context and especially place of residence are critical to our understanding of screening behaviors in this population.

Le dedico esta tesis a mamá y papá

Catarino y Faustina Montoya

que con su amor, apoyo, y sacrificio me han ayudado a completar este proyecto.

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CHAPTER 1

Introduction

An increasing number of cancer research studies point to Latinas' disproportionate burden of breast and cervical cancer. Despite having lower breast cancer incidence rates than non-Latina White women (National Cancer Institute [NCI], 2008), Latinas are at higher risk of being diagnosed at later stages, significantly decreasing treatment options. The 5-year breast cancer survivorship rate for Latinas is lower than for non-Latina Whites, 85.8% and 88.5%, respectively (American Cancer Society [ACS], 2009). As a result, breast cancer is the leading cause of death among Latina women (ACS, 2009). Latina women also have higher cervical cancer incidence rates, 13 per 100,000, compared to 8 per 100,000 among non-Latina White women (NCI, 2008a). The cervical cancer mortality rate for Latinas is 3 per 100,000 compared to 2 per 100,000 for non-Latina White women (NCI, 2008a). The lower breast cancer survivorship and higher cervical cancer incidence and mortality rates among Latina women are primarily attributed to this group's lower mammography and Pap smear screening participation (ACS, 2009).

Latinas' Mammography and Pap smear Screening Rates

The United States Preventive Services Task Force (USPSTF) recommends biennial mammography screening for women ages 50 to 74 years (2009). For cervical cancer, the USPSTF recommends that a woman begin screening three years after the onset of sexual activity or once she reaches the age of 21 years old, and that she continue receiving a Pap smear exam at least every three years (2003). However, the American Cancer Society (ACS) has slightly different screening guidelines. The ACS recommends that women over the age of 40 obtain an

annual mammography, and that women start receiving an annual Pap smear exam no later than age 21 (ACS, 2011).

Latinas have consistently shown lower breast and cervical cancer screening rates than non-Latina White women. Data from the 2005 National Health Interview Survey (NHIS) indicate that only 59.6% of Latinas report having had a mammography exam within the past two years compared to 68.1% of non-Latina White women (ACS, 2009). Similarly, Latina women are less likely to adhere to Pap smear screening guidelines than non-Latina Whites, with 74.5% of Latinas reporting a Pap smear within the past three years compared to 81.4% of non-Latina White women (ACS, 2009).

Adherence to breast and cervical cancer screening varies across Latina subgroups (Gorin & Heck, 2005; Howe et al., 2006; Ramirez et al., 2000). Mexican women report the lowest mammography screening rates at 56.2% and Cuban women the highest at 72.2% (ACS, 2009). Moreover, studies that take into account nativity status show wide differences in screening participation between Mexican immigrants and U.S.-born women of Mexican descent. For example, only 49% of Mexican immigrant women report having had a mammogram within the past two years in comparison to 76% of those born in the U.S. (Wallace, Gutiérrez, & Castañeda, 2008). Mexican women also have lowest cervical cancer screening rates: 73.3% of Mexican women report having had a recent Pap smear in comparison to 77.7% among their Puerto-Rican counterparts (ACS, 2009). Due to Mexican immigrants' documented low cancer screening participation rates, this study will focus on the screening behaviors of immigrant Mexican women living in Little Village (LV), Chicago.

Known Influences on Screening

Multiple structural, cultural, and individual-level barriers contribute to Latinas' lower cancer screening participation rates. For example, socioeconomic status, nativity status, insurance status, access to health care, language, and cultural health beliefs have been found to influence screening rates (Buki, Borrayo, Feigal, & Carrillo, 2004; Carasquillo & Pati, 2006; Otero-Sabogal, Owens, Canchola, Golding, Tabnak, & Fox 2004; Wallace et al., 2008). Other distal community factors such as institutional regulations, social and economic policies, media influences, and political climate also influence screening behavior (Akers, Newman, & Smith, 2007; Wells & Roetzheimen, 2007). However, despite our knowledge of these variables, we know much less about how they interact with each other. That is, we have a limited understanding of the intersection of distal factors and proximal factors (e.g., nativity status and insurance status) shaping Latina immigrants' screening behaviors.

In this effort, examining the role of place can aid our understanding of the multifaceted and interrelated determinants of women's cancer screening behavior. For the purpose of this study, "place" is operationalized as the community in which women obtain early cancer detection information and participate in cancer screening services (Akers et al., 2007; Ramirez et al., 2000). To understand the role of place on screening behavior, I will be applying Bronfenbrenner's Ecological Model (Bronfenbrenner, 1979) because it recognizes the complex influence of contextual factors on individual behavior. These contextual factors are organized into five levels: (a) intrapersonal, (b) interpersonal, (c) institutional/organizational, (d) cultural/community, and (e) public policy. Applying the Ecological Model to women's screening behaviors at the intrapersonal level would encompass individual characteristics such as knowledge, attitudes, beliefs, and emotions associated with breast and cervical cancer screening.

Interpersonal factors would refer to women's interactions within their social networks, including the support received from family and friends toward a cancer screening exam. Next, the institutional and organizational factors would include the social institutions, policies, and regulations that determine access to cancer screenings and non-health-related services. The cultural and community level would refer to the socio-historical conditions and environmental factors influencing cancer screening. Finally, the public policy level refers to the laws and policies that determine the level and extent of intrapersonal, interpersonal, and institutional factors affecting screening behaviors. For the proposed study, the theoretical conceptualization posits that place intersects all five levels of the Ecological Model, and that all levels of the model need to be taken into account to gain a better understanding of women's cancer screening behaviors.

This investigation is a two-phase, mixed-method study that examines the social context in LV that contributes to women's high cancer screening rates. In the first phase of the study, I examined the knowledge, attitudes, beliefs, and emotions of 41 Mexican immigrant women regarding breast and cervical cancer (including etiology, symptoms, and prognosis) as well as their screening practices. In the second, qualitative phase, I examined the community-level factors that contribute to cancer screening adherence among Mexican immigrant women living in LV. I conducted in-depth interviews with knowledgeable community members to learn about the various community-level factors influencing screening behaviors. To assess Little Village's readiness to address breast and cervical cancer screening participation, I examined the following: (a) Current programs or services on breast and cervical cancer screening; (b) level of knowledge about breast and cervical cancer screening programs among women; (c) extent of support toward programs and services related to breast and cervical cancer screening efforts; (d) the prevailing

attitude of the community toward breast and cervical cancer screening; (e) community knowledge about breast and cervical cancer, including the importance of cancer screenings; and (f) availability of local resources (e.g., people, time, money, space) to support breast and cervical cancer screening efforts. To my knowledge, this is the first study designed to explain community factors that account for high cancer screening rates among Mexican immigrant women.

Influence of Place on Screening Behavior

An examination of the role of place can help elucidate the complex interactions between the different level factors outlined in the Ecological Model and how these influence an individual's health behaviors. To better understand the intrapersonal factors influencing Mexican immigrant's screening behavior such as knowledge and beliefs, we must contextualize how women obtain information about cancer and access screening services. Known predictors of cancer screening participation that are place-based include access to care, access to information about breast and cervical cancer, and knowledge about screening services available within their communities. Although research has examined the association between each variable --or even a few at a time--and screening, we still have limited knowledge about the larger context in which all of these variables interact to impede or foster screening behaviors. Thus, a broader lens that encompasses place of residence is necessary to understand the multiple and interrelated factors Latina immigrant women encounter. Examining the role of place is also imperative, as community-based efforts to increase awareness about the importance of early detection have been effective. For example, Buki and colleagues (2004) found that in a diverse Latina sample, women who were most likely to be up to date with screenings were those whose immediate context provided information about the importance of screening and facilitated local access to screening services.

Extant research on Latinas' cancer screening rates and the role of place centers around rate differentials reported by women living in rural and urban areas. These studies point to most rural communities' lack of capacity and infrastructure to serve a growing Latino immigrant population (Cristancho, Garcés, Peters, & Mueller, 2008). A more focused examination on the role of place can provide insight into the association between women's cancer screening behavior and the local context of health care institutions and services. In addition to investigating the organization and structure of health care systems, researchers must examine and understand the role of the local social context on women's screening behaviors.

Breast and cervical cancer screening participation rates among Latina immigrant women vary significantly by geographic location. A few studies have found that women living in communities with a high concentration of Latinos and in communities that are economically deprived have the lowest participation rates (Akers et al., 2007; Wells & Horm, 1998). Similarly, in studies examining Latinos, researchers have found significant variations in cancer morbidity and mortality rates based on neighborhood characteristics (Eschbach, Mahnken, & Goodwin, 2005; Martinez-Tyson, Pathak, Soler-Vila, & Flores, 2009).

Access to care (e.g., availability of clinics serving immigrant populations in the area), a factor that is influenced by place, has been consistently found to predict cancer screening behaviors among Latina women even after controlling for socio-demographic factors (Carrasquillo & Pati, 2004; Gorin & Heck, 2005; Wells & Roetzheim, 2007). Among Latinas, Mexican immigrant women are the least likely to have health insurance, a regular source of care, or have seen a health care provider recently (Gorin & Heck).

Place is related to other facilitative factors beyond access to care, including social service agencies and non-health organizations that serve the Latino immigrant population. Access to

culturally and linguistically appropriate health care information and services is another important place-based variable that has been cited as a determinant to screening (Gany, Herrera, Avallone, & Changrani, 2006; Jacobs et al., 2005). For example, Latina immigrants report receiving information on the importance of cancer screening from community sources such as community organizations and church more often than from their health care providers, clinics, or hospitals (Gany et al., 2006). Examining the role of institutions and organizations is essential in understanding health behaviors and outcomes among Mexican immigrant women as they structure of opportunities and barriers to health care services (Burke, Joseph, Pasick, & Barker 2009). Especially since non-health care community organizations such as advocacy groups and religious organizations are effective players in interventions oriented toward improving cancer prevention among Latinos (Puschel, Thompson, Coronado, Lopez, & Kimball, 2001). An examination on the role of place can elucidate existing facilitative factors at the community-level among communities where its residents are predominantly uninsured monolingual Spanish speakers.

Facilitative factors such as social networks and culturally aware organizations or institutions are distinctive to place. These facilitative factors can “create support and enable resiliency among community members to promote health” (Bigby, 2007, p. 225). For example, immigrants who settle and live in well established communities may learn to navigate the health care system much faster than those in communities with a relatively small Latino or immigrant populations (Wallace et al., 2008). Thus the availability of culturally and linguistically distinct health organizations, resources, and services within a community are important to take into account when examining screening participation rates.

Cancer Screening Rates in Little Village

Contrary to most findings about Latina immigrants, evidence suggests that Latina immigrant women in LV have high cancer screening participation rates (Shah & Whitman, 2005). In a large community health survey of six different communities in Chicago, Shah and Whitman found that women living in LV have higher breast and cervical cancer screening rates than women in more affluent and predominately White communities (2005). Specifically, 87% of the women living in LV reported having had a mammography exam and 90% reported having had a Pap smear at some point in their lives. The high screening rates among Mexican immigrant women living in the LV community in Chicago warrant additional research on the role of place and specific community level factors that encourage this high-risk group to receive cancer screenings. Examining the role of place will aid to our understanding of the intersection between community factors and individual-level characteristics that shape Latina immigrant women's cancer screening adherence. This investigation can help elucidate the mechanisms by which community level factors foster cancer screening awareness and participation among its residents. With this information, appropriate policies, programs and interventions aimed at reducing the cancer screening disparities experienced by this group can be designed. Moreover, knowledge about positive community factors present in LV may be transferred to other locations where Mexican immigrant women have lower than average screening rates.

CHAPTER 2

Review of Relevant Literature

This chapter provides a review of current literature on breast and cervical cancer screening among Mexican immigrant women with a special emphasis on the need to examine the role of social context and place of residence on their mammography and Pap smear participation. I will use the Ecological Model as the guiding theoretical framework to conceptualize the multiple factors influencing women's screening behaviors (Bronfenbrenner, 1977, 1979). The chapter ends with an introduction to the Community Readiness Model, which will guide the methodology of the second phase of this research project (Oetting, Donnermeyer, Plested, Edwards, Kelly, & Beauvais, 1995).

Social Context and Screening Behavior

Despite the importance of contextualizing health behaviors, social context is rarely the focus of cancer screening studies conducted with Latina women (Burke et al., 2009; Pasick, Barker, Otero-Sabogal, Burke, Joseph, & Guerra, 2009). Social context is defined as the social and cultural forces that shape an individual's everyday experiences, and include historical events, political structures, immigration processes, institutions, and resources (Krieger, Emmons, & Williams, 2009). Even individual behaviors such as obtaining cancer screenings do not take place in isolation from social and cultural influences, but rather are influenced by them. In fact, there is evidence that social context is an essential component to research on this topic, as Latina immigrants' daily experiences outside the health care setting greatly influence their health status and behavior (Viruell-Fuentes, 2007). Consequently, it is essential that we expand our understanding of Mexican immigrant women's screening behavior by placing it within the social context in which women live. Therefore, social context should not be ignored or relegated to a

“background variable” but rather considered a major influence on women’s beliefs, attitudes, and health behaviors (Rajaram & Rashidi, 1998).

Another limitation in the current literature is that a significant number of studies on cancer screening disparities focus on individual-level characteristics, especially cultural factors that influence Latinas’ mammography and Pap smear participation (e.g., Borrayo, & Jenkins, 2001, 2003; Buki, Borrayo, Feigal, & Carrillo, 2004; Gany et al., 2006; Ramirez et al., 2000a). Studies that focus on cultural differences to explain Latina immigrants’ lower cancer screening rates have contributed to our understanding of these disparities. However, only using cultural explanatory paradigms also has some limitations. The focus on socio-cultural explanations diverts attention from the structural factors that contribute to wide disparities in access and utilization experienced by this population (Viruell-Fuentes, 2007). As a marginalized group, Mexican immigrant women’s adherence to cancer screening exams needs to be contextualized within a larger framework, as it is critical to understand how structural and systemic inequalities contribute to lower utilization of preventive health services. Recent studies point to the need to contextualize cultural explanatory models within the structural inequalities that Latina immigrants experience, such as unequal access to health care services, segregation, racism, and discrimination (Zambrana & Dill, 2005).

Therefore, to address the aforementioned limitations, an ecological perspective will be used in the present study. An ecological perspective recognizes the importance of social context and place to understanding Mexican immigrant women’s screening participation. The focus on place allows for the examination of a woman’s access to screening resources and experience within and outside a health care setting, namely the structural and institutional forces that

influence the context for her health decision-making process, and eventually for her decision to screen.

The Role of Place of Residence

For the purposes of this study, place will be operationalized as the community in which women live, as it plays a significant role in promoting health behaviors of its residents (Bigby, 2007). Research on how place influences Latina immigrants' participation in cancer screening exams is scarce. Place influences a woman's health status through the availability, accessibility, and quality of health information and services (Akers et al., 2007). In this investigation, the purpose of focusing on the role of place is threefold. First, it can help bring to light inequalities that women experience in receiving breast and cervical cancer screening information and services. Second, it can elicit ways in which women overcome these inequalities. Finally, it allows for an examination of key structural and institutional forces (e.g., local efforts such as services, policies, and programs), and their influence on women's screening behaviors. Examining the processes through which place affects an individual's health seeking behavior is essential to the elimination of cancer screening disparities among Latina immigrants. To my knowledge, no previous study has examined the role of place on screening behavior among this population.

Current studies on cancer and the role of place have focused on the association between breast and cervical cancer incidence and mortality rates and the racial or economic composition of a neighborhood (e.g., Eschbach et al., 2005; Reyes-Ortiz, Eschbach, Zhang, & Goodwin, 2008). Other research on the role of place focuses on transportation-related issues among women who live in geographically isolated or rural communities (Coronado, Thompson, Koepsell, Schwartz, & McLerran, 2004; Hubbell, 2006). Although researchers have alluded to the

influence of specific health system factors on screening (e.g., Gany et al., 2006), they have not explored how such factors can be determined by place.

One of the clearest indicators of the importance and influence of place on screening behaviors is the difference in screening rates based on geographic location. Ramirez et al. (2000) found significant differences in breast cancer screening exam rates among Mexican American women living in different cities within the same state (TX) and across different states (CA and TX) despite very similar population socio-demographic and health care characteristics. For example, Mexican American women living in San Francisco were more likely to report having had a mammography screening exam within the past two years (60%) than those living in San Antonio, Houston, or Laredo, whose screening rates were 59%, 55%, and 45%, respectively (Ramirez et al.).

Acknowledging the importance of place, this study focuses on understanding local factors that contribute to the higher-than-average screening rates reported by Mexican immigrant women living in Little Village (LV), a large Mexican immigrant community in Chicago. Despite having socio-demographic characteristics that place them at high risk of underutilizing health promotion services, women living in LV report high mammography and Pap smear screening rates. In 2002, a study of six different communities in Chicago found that LV was the community with the highest screening rates (Shah & Whitman, 2005). Eighty-seven percent of women in LV over the age of 39 reported having had a mammogram within the past 2 years, in comparison to 79% of their counterparts living in Norwood Park, a predominately non-Latino White and more affluent community in the city (Shah & Whitman). Similarly, women living in LV had a 90% Pap smear screening rate within the past 3 years, in comparison to 71% of women from Norwood Park. These high screening rates are at odds with the larger body of literature

suggesting that immigrant women face some of the highest barriers to screening. Thus, there is a need to confirm findings with new data and understand the factors that account for the high mammography and Pap smear screening participation rates among women residing in LV, should they still be high.

Using the Ecological Model to Conceptualize Influencing Factors

I use Bronfenbrenner's Ecological Model (EM) to conceptualize the multiple factors that impede or encourage cancer screening participation among Latina immigrants. Consistent with the importance of the role of place on screening behavior, one of the central tenets of this model is that individual-level health behaviors need to be understood within the social context of people's everyday lives. Specifically, the EM recognizes that many factors present at five different levels influence an individual's health behavior (Bronfenbrenner, 1979). The intrapersonal level refers to individual characteristics (e.g., knowledge, attitudes) that influence screening behaviors. The interpersonal level encompasses a woman's social network and its effect on screening participation. The institutional and organizational level includes the health and non-health-related social institutions, policies, and regulations that determine timely access to cancer screening services. The community and cultural level refers to the community climate, which is composed of: (a) context such as socio-historical conditions, (b) relations among organizations, institutions, and networks; and (c) power relations and power structures. Finally, the public policy level encompasses the laws and policies that direct and fund national, state, and local efforts around issues of breast and cervical cancer screening. Next, I discuss each of these levels in detail.

Intrapersonal Level

The majority of the literature on Latinas' cancer screening behaviors centers on the intrapersonal-level factors that enable or impede cancer screening adherence. For example, a woman's cultural beliefs and attitudes (Borrayo & Jenkins, 2001, 2003; Buki, Borrayo, Feigal, & Carrillo, 2004; Ramirez et al., 2000a), lack of knowledge and misconceptions about cancer and their respective screening exams (Gany et al., 2006), and acculturation level (Borrayo & Jenkins, 2003; Peragallo, Fox, & Alba, 2000) have been shown to influence women's screening participation.

Specifically, research on intrapersonal factors focuses on the woman's health beliefs and attitudes in which feelings of fear, shame, anxiety, and embarrassment have been identified to impede women from obtaining a mammogram or Pap smear (Austin et al., 2002; Borrayo & Jenkins, 2001; Garbers et al., 2003). Latina women have also been found to have negative or fatalistic views about developing breast and cervical cancer, making them less likely to adhere to screening guidelines (Austin et al.). However, studies have discovered that these predictors of screening behavior may vary according to socio-demographic characteristics, exposure to education about the importance of early detection, and access-related factors, resulting in screening rate variations across immigrant groups and communities (Buki, Jamison, Anderson, & Cuadra, 2007; Gany et al., 2006).

Lack of knowledge about screening guidelines and misconceptions about breast and cervical cancer have also been found to contribute to Latinas' lower mammography and Pap smear screening rates (Ramirez et al., 2000; Scarinci, Beech, Kovach, & Bailey 2003; Valdez et al., 2001). Latinas, especially women of Mexican descent, are less likely to know about current cancer screening guidelines than non-Latina White women (Bocanegra, Thrin-Sherin, Herrera, & Gany, 2009; Ramirez et al., 2000; Scarinci et al., 2003; Valdez et al., 2001). Women lack

awareness about breast and cervical cancers, including their causes, etiology, and risk factors (Austin et al., 2002). Even when Latinas have basic knowledge about mammography screening and breast cancer risks, they often lack specific information about where to get screened or the resources available in their community that help with the cost of the exam (Valdez et al., 2001).

Acculturation also is another factor that has been widely studied as influencing screening adherence among Latina immigrants. Acculturation is defined as a bilinear and multidimensional process by which an individual is transformed through social interaction in a new cultural context (Zea, Asner-Self, Birman, & Buki, 2003). Studies indicate that recent immigrants tend to be less acculturated and less knowledgeable about cancer screening guidelines, the U.S. health care system, and the screening services available in their respective communities, in comparison with women who have been in the U.S. longer (Bocanegra et al., 2009; Cristancho et al., 2008; Peragallo et al., 2000; Scarinci et al., 2003). Yet, other studies report that the association between a woman's acculturation level and her mammography and Pap smear screening behaviors is not statistically significant or disappears after adjusting for socioeconomic status and other structural factors, such as age, education level, and income (Abraído-Lanza, Chao, Gates, & Gates, 2005). Therefore, more research is needed to create a holistic picture of the associations among acculturation level, community influences, and screening behavior. Acculturation has typically been measured by a woman's birthplace, generation, time in the United States, and/or English language proficiency, which do not take into account context-specific variables such as place of residence. Although acculturation has contributed to our understanding of screening patterns for Latina women, it does not completely capture the experiences of all Mexican immigrants or always reflect the social, economic, cultural, or the geographic variations of communities that

also influence their health behavior (Carter-Pokras, 2008). Thus, placing acculturation within an ecological framework aids our understanding of Latinas' screening utilization patterns.

Latina immigrant women may exhibit many of the aforementioned intrapersonal barriers and still obtain screening exams regularly. For example, immigrant Salvadoran women living in Washington D.C. reported a 100% mammography screening rate despite having many misconceptions about breast cancer risk factors and the effectiveness of mammograms (Buki et al., 2004). The optimal screening rates reported by the women were attributed to the fact that they had been recruited at a senior center that facilitated access to breast cancer information and screening services (Buki et al.). Thus, additional research on the role of place is needed, as the local community may effectively mediate intrapersonal level factors otherwise known to hinder screening participation.

Interpersonal Level

The primary interpersonal factors found to positively influence Latina women's screening participation are strong social networks and positive provider-patient interactions (Suarez et al., 1994; Otero-Sabogal et al., 2004; Suarez et al. 2000; Tejada, Thompson, Coronado, & Martin, 2009). Social networks provide a buffering effect, as they facilitate exchange of information and resources. For Latina immigrants, their social network may also be the only source of information on the importance of cancer screening (Suarez et al., 2000; Tejada et al.). Thus, a woman's social network can be an enabling factor among immigrant populations because it plays a key role in influencing women's attitudes toward a mammogram and Pap smear screening exam (Katapodi et al., 2002; Suarez et al., 1994). Additionally, social networks have been found to provide other types of support such as money, transportation, and information about resources within the community.

Along with the influence of support from social networks, positive provider-patient relationships are important aspects to examine when studying Latina immigrants' screening adherence (Borrayo, Thomas, & Lawsin, 2004; Otero-Sabogal et al., 2004). Having a physician's recommendation and receiving annual reminders in the mail are predictors of mammography and Pap smear screening (Peek & Han, 2004; Tejada et al., 2009). Latina immigrants who have reported negative experiences with a health care provider, such as not confiding in their provider or feeling that they were not treated with respect, are less likely to report receiving screening exams (Carasquillo & Pati, 2006). Thus, it is important to understand Latina women's communication and personal experiences when they seek medical care.

Institutional and Organizational Level

Research on Latinas' cancer screening practices has consistently found that having access to health care is one of the strongest predictors of cancer screening participation. Having a regular source of care is essential for receiving breast and cervical cancer screening (Gorin & Heck, 2005; Valdez et al., 2001; Wallace et al., 2008). For example, a recent study of Mexican immigrants' access to preventive health services found that in comparison with women who had a regular source of care, women who reported no usual source of care had odds 3.09 greater for not having a mammography exam in the past 2 years, and odds 1.72 greater for not having had a Pap smear in the past 3 years (Wallace et al.). Latina women who have regular access to care through community clinics and other safety net facilities in their communities are likely to have an easier time obtaining mammography and Pap smear cancer screening exams regardless of insurance status (Shah & Whitman, 2005). In addition to health system infrastructure, provider availability and patient characteristics at the local level have shown to influence screening participation (Akers et al., 2007; Puschel, et al., 2001; Wells & Roetzheim, 2007).

In a large national community sample ($n = 462$) of uninsured Latinas living in four U.S. cities (Dallas, TX; Hartford, CT; Newark, NJ; and Washington DC), researchers found regional differences in mammography screening rates based on recruitment site (Buki et al., 2007). Participants residing in TX and CT were almost four times as likely as other women to have received a mammogram at least once in their life. Similarly, regarding women's probability of being up to date with mammography screening, participants from CT had an odds ratio 7.71 times higher than women from the other locations (Buki et al.). The higher mammography screening rates among women in CT were attributed to the fact that participants from that city were recruited from a community health clinic that provided high quality, culturally-tailored, bilingual access to mammography services (Buki et al.).

Differential access to health care resources also leads to differences in mammography and Pap smear screening practices between immigrant and U.S.-born Latinas (Carasquillo & Pati, 2006; Goel Wee, McCarthy, Davis, Nigo-Metzger, & Phillips, 2003; Gorin & Heck, 2005; Wallace et al., 2008). Only 73.2% of Mexican immigrant women report having had a mammography screening in the past 2 years vs. 78.1% of their U.S.-born counterparts (Wallace et al.). With respect to the Pap smear, 73% of Mexican immigrant women report having had one in the past three years in comparison to 80% of U.S.-born Latinas (Wallace et al.). Two main factors that explain these differential rates are access to medical care and length of stay in the United States (Tejada et al., 2009; Wallace et al., 2008).

First, the differences in mammography and Pap smear screening among U.S.-born and immigrant women have been found to dissipate after adjusting for access to care (Goel et al.), a factor that can be ameliorated by the local community context. Second, established immigrants (living in the U.S. for more than 10 years) are more likely to engage in preventive care than those

who are newly arrived (Tejada et al.; Wallace et al.). For example, when Wallace et al. stratified the screening rates of Mexican immigrant women further into recent and established immigrants, wider differences were found in Pap smear screening rates, 66.5% vs. 80.0%, respectively (Wallace et al.).

Thus, in this section I argue that all health care is local. Despite national policies and larger institutional structures in place, women ultimately have access to breast and cervical cancer screening information and services based on the resources available at the local level (Puschel et al.). Research on the screening participation of a specific Latino immigrant community, therefore, can provide insight into important access-related factors. Studies suggest that a health care system that is easy to navigate, where bilingual health care professionals are available, and where women can access culturally appropriate cancer detection information, is more likely to be associated with higher screening participation rates (Ramirez et al., 2000; Shah & Whitman, 2005).

In addition to having an adequate infrastructure and capacity, community institutions and organizations must also have knowledge about the population they are serving to improve screening utilization. Yet, a study that compared health care providers' perceptions of cancer screening barriers experienced by Mexican women with the women's own perceptions of barriers found wide discrepancies between the groups' responses (Puschel et al., 2001). For example, medical and organization representatives did not perceive access to or availability of low cost care to be a barrier to cancer screening, yet half of Mexican residents reported not having a regular provider (51%) and not being aware of low cost services available in the community (45%) (Puschel et al.). This study points to the lack of awareness among community

institutions of the actual barriers faced by Latina immigrants in obtaining cancer screening services, which can hinder efforts to improve screening rates.

In contrast, when community organizations recognize the obstacles that Latina immigrants experience when seeking preventive care, mammography and Pap smear screening rates can be improved. Previous studies have shown the importance of increasing cancer screening awareness in community settings (Gany et al., 2006). For example, community-based organizations can be effective in helping Latina immigrants navigate the health care system, develop awareness of screening resources, or obtain health information because they are a trusted source of information among residents (Bigby, 2007) . The receipt of health information, including the importance of cancer screening through community resources (i.e., workshops, print media, and radio commercials) has been identified as enabling factor to Pap smear screening among low income Latina immigrants (Scarinci et al., 2003).

Further evidence supports the influence of place on access to screening information and mammography and Pap smear screening participation. Buki et al. (2007) reported that Latina immigrants with exposure to cancer education were more likely to obtain cancer screening exams compared to women who had not received any type of cancer education. Specifically, women with less than 6 years of formal education, with prior exposure to cancer education (defined as having attended an education presentation on the importance of early detection), had a 6.07 odds ratio of having received a mammography compared to women without exposure to cancer education. Further, women with exposure to cancer education had a 1.60 odds ratio being up to date with Pap smear, compared to women who had no exposure to cancer education (Buki et al.). Despite the women being low income and uninsured, findings showed a positive

association between exposure to cancer education and initial mammography screening as well as repeated Pap smear screening.

Community and Cultural Level

Given the evidence that Latina women still adhere to screening recommendations despite their uninsured status, it is important to examine the community factors (e.g., availability of low cost services) that may account for these findings (Shah & Whitman, 2005). Factors at this level include a community's socio-historical conditions, organizational and institutional networks, and power relations and power structures (Bronfenbrenner, 1977, 1979; McLeroy, Bibeau, Steckler, & Glanz, 1988). Socio-historic conditions are important to consider when examining Mexican immigrant women's screening behaviors because health services and resources have been unequally distributed, disproportionately affecting this population's access to health care (Zambrana & Dill, 2005). Latino immigrants typically reside in economically disadvantaged communities with poor access to resources and limited community power. Yet, power structures play a critical role in defining health problems and allocating resources to address such problems. Economically disadvantaged communities face several hard decisions when they have fewer resources to allocate for the many problems present within the community.

The relationship among organizations and institutions within the community, including health care providers and community-based organizations, also influences residents' access to health resources available in a community (McLeroy et al., 1988). In particular, these organizations and institutions are in charge of the design, implementation, and delivery of health-related services (McLeroy et al.). Consequently, medical and community-based organization must be attuned to the needs of community women to effectively provide screening resources.

Organizations have the unique opportunity of increasing a woman's knowledge about screening services and ultimately mammography and Pap smear screening adherence.

Public Policy Level

In the present study, public policy factors encompass a woman's socio-economic, health insurance, and immigration status. These factors have traditionally been examined as intrapersonal factors that influence cancer screening (Abraído-Lanza, Chao, & Gammon, 2004; Carrasquillo & Pati, 2006; Coughlin et al., 2004; Echeverria & Carrasquillo, 2006; Freeman & Lethbridge-Cejku, 2006; Wallace et al., 2008). However, I argue that such factors should be contextualized within the public policy level of the EM, as these factors are influenced by, arise from, and can often be addressed through, public policy.

First, Latinas are overrepresented in lower economic levels and, thus, are less likely to participate in cancer screening compared to non-Latina White women (Abraído-Lanza et al., 2004; Otero-Sabogal et al., 2004). Specifically, Mexican immigrants represent the largest proportion of women who forgo medical care due to financial constraints that result from their low socioeconomic level (Freeman & Lethbridge-Cejku, 2006). Latinas also experience wide educational gaps placing them at risk of not receiving information about cancer screening exam guidelines. The educational profile of Latina women is concerning: 36% of Latinas have less than a high school degree compared to 10% of their non-Latina White counterparts. Additionally, only 51% of Latina immigrants are high school graduates (Gonzalez, 2008). A woman with low educational levels may not be knowledgeable about breast and cervical cancer screening guidelines or have access to information about the importance of early detection. Thus, it would be expected that in Mexican immigrant communities where there is a high proportion of

women in the lower socioeconomic levels, women may be especially vulnerable to not receiving breast and cervical cancer screening information.

Second, being insured is a major predictor of breast and cervical cancer screening adherence (Bocanegra et al., 2009; Carasquillo & Pati, 2004). The most recent data on health insurance shows that Latino adults are more likely to be uninsured (32.3%) than non-Latino Whites (10.7%) (DeNavas-Walt, Proctor, & Smith, 2009). Within the Latino population, individuals of Mexican descent and immigrants have consistently shown low levels of health insurance coverage (Freeman & Lethbridge-Cejku, 2006). For example, 44% of Latina immigrants lack health insurance compared to 14% of naturalized citizens and 12% of U.S.-born women (Echeverria & Carrasquillo, 2006).

Third, related to a woman's immigration status are access to care and language barriers. A woman who is undocumented has limited access to care, given that she is unlikely to qualify for various health care services and financial programs (Marshall et al., 2005). However, even when immigrant women qualify for such services, language barriers may contribute to their decreased access to health care services. Latina immigrants who are Spanish monolingual experience more difficulty navigating the health care system and communicating with English monolingual health care professionals than women who are bilingual or English proficient, placing them at risk of not receiving adequate health promotion services (Bocanegra et al., 2009). The limited availability of bilingual services can also result in inaccurate information exchange about symptoms, unequal medical treatment, and even misdiagnosis (Marshall et al., 2005). Not surprisingly, immigrants with limited English proficiency are more likely to report higher rates of dissatisfaction with the quality of medical care received, and to perceive a lack of respect from health care providers, than immigrants with higher levels of English proficiency

(Gany et al., 2006). In addition, women with limited English proficiency are less likely to receive a Pap smear exam than women from the same race or ethnicity who are bilingual or speak only English (Jacobs et al., 2005). Language access, such as the availability of bilingual health services is dependent on place and varies across different communities (Casey, Blewett, & Call, 2004).

Policies are needed to address Latina immigrant women's socioeconomic, insurance, and immigration status in order to improve their screening rates. Findings on the influence of socioeconomic status on screening strongly support the need for public policy to address financial barriers among low income women (Gany et al., 2006; Shah & Whitman, 2005). An example of a relevant policy would be to increase the availability and quality of safety net clinics so that uninsured immigrant women can obtain needed screening exams.

At the state level, Illinois has instituted several policies to improve breast and cervical cancer screening rates among low income and uninsured minority women. The Illinois Breast and Cervical Cancer Program (IBCCP) and Stand Against Cancer (SAC) are initiatives designed to increase screening resources for uninsured low-income women living in the state of Illinois. Launched in 1995, the IBCCP is a state-funded program that offers free mammograms and Pap smear screening as well as low cost breast and cervical cancer treatment to uninsured, low-income women (Illinois Department of Public Health [IDPH], 2010). The SAC program also provides educational outreach and case management for women residing in low-income communities through a network of collaborations with faith-based organizations, churches, health care and community organizations, and the American Cancer Society. Their outreach efforts include the use of lay health workers from participating churches who conduct outreach

and education efforts and refer women in need of exams to partnering clinics and hospitals (Shapiro, Thompson, & Calhoun, 2006).

Most recently, the state of Illinois passed the Breast Cancer Quality Screening and Treatment Initiative, a joint program between the Illinois Department of Healthcare and Family Services and Department of Public Health. This initiative will establish pilot projects in three communities focusing on educating women about early detection and breast cancer treatment (Illinois Department of Healthcare, 2010). Thus, the state of Illinois has policies aimed at improving the screening rates of Latina women. However, Shapiro et al. (2006) have noted that one of the downfalls of the aforementioned screening efforts is their strong reliance on community health centers that traditionally do not receive sufficient funds to meet the medical needs of their patients.

The influence of language and culture on health care access and utilization has also been recognized at the policy level with the passing of the national standards on Culturally and Linguistically Appropriate Services (CLAS). CLAS was established by the federal government to facilitate linguistic access to public services among minority and immigrant populations (U.S. Department of Health and Human Services, 2001). The CLAS standards are directed at health care organizations to ensure that patients with limited English proficiency, such as immigrants, receive timely and quality health care services. The CLAS standards require that health care organizations use the standards to make their practices more culturally and linguistically accessible. For example, health care organizations must provide language assistance services, such as bilingual staff or interpreter services, at no cost to patients with limited English proficiency in every patient visit. Although the ultimate goal of CLAS standards is to reduce

racial and ethnic health disparities, it is an unfunded mandate that is yet to be implemented by all health care organizations.

Despite the importance of focusing on public policy, too few studies have examined this issue (Akers et al.; Wells & Roetzheimen, 2007). Because public policy has the potential to mitigate intrapersonal factors, national-, state-, and local-level policies are needed to increase language access, availability of bilingual health services, and community-based resources related to screening information and services. Specifically, Latino immigrant communities need exposure to information about the importance of early detection, screening guidelines, and breast and cervical cancer (Akers et al., 2007; Bocanegra et al., 2009). As research has shown, this exposure is important because it can lead to Latina immigrant women's mammography and Pap smear screening participation (Buki et al., 2007).

Using the Community Readiness Model to Understand Latina Immigrants' Cancer Screening Behaviors

I use the Community Readiness Model (CRM) to guide this investigation's methodology (Oetting et al., 1995). The CRM methodology consists of assessing the "readiness" of a community to address a health issue by interviewing leaders of the community who can speak about their professional, social, and community experiences and observations regarding the health behavior at hand. Additionally, the CRM adopts a strength perspective by taking into account current and potential resources including time, people, money, and space available for prevention efforts (Plested, Edwards, & Thurman, 2006). It emphasizes that all communities are different and that the specific social climate, resources, and leadership characterizing each community determine its ability to address a health issue. The CRM includes six elements to examine a community's readiness and can be modified to different health issues. The following

are the CRM's six elements as they pertain to the issue of breast and cervical cancer screening in LV:

- a) Current efforts, programs, or policies on breast and cervical cancer screening that target women living in LV;
- b) Level of knowledge about breast and cervical cancer efforts, programs, or policies among women in the community;
- c) Extent of support from appointed leaders and influential community members toward programs and services related to breast and cervical cancer screening efforts;
- d) The prevailing attitude of LV community toward breast and cervical cancer screening;
- e) Community knowledge about breast and cervical cancer, including the importance of cancer screening and how screening services influence the Mexican immigrant community, and
- f) Availability of local resources (e.g., people, time, money, space) to support breast and cervical cancer screening efforts (Plested, Edwards, & Thurman, 2006).

According to the CRM, a community's readiness to address an issue can be classified into 1 of 9 stages, starting from the *No Awareness* stage, in which the community and its leaders do not recognize the issue as a problem, to the *Professionalization* stage, in which a community and its leaders are knowledgeable about the prevalence, risk factors, and causes associated with the issue (Plested et al.). Importantly, the CRM provides guidelines about how to develop interventions tailored to a community's readiness stage, optimizing resources to change the health behavior.

The CRM is consistent with the Ecological Model and with the notion of place because it uses the community as the unit of analysis. The CRM also recognizes the multiple influences on health behavior shaped by the community. It can be used as a tool to assess a health issue within a community, but most importantly it is a tool that allows the community to identify effective strategies to prompt prevention initiatives (Jumper-Thurman, Plested, Edwards, Helm, & Oetting, 2001). A major strength of the CRM is that it describes a community as a place that is geographically defined, but a place that is also “fluid and always changing, adapting, and growing” (Edwards, Jumper-Thurman, Plested, Oetting, & Swason, 2000). Thus, each community is conceptualized as having unique features based on the people who live there, its health care system, and community resources. The CRM also highlights the fact that communities can move through a series of stages to develop, implement, maintain, and improve health behaviors.

Consequently, the multifaceted and comprehensive approach of the CRM model fits with the purpose of the present study of examining the different level factors influencing the screening participation of Latina immigrants. Another aspect of the CRM design that is consistent with the EM is that it collects information about the health issue at hand from a diverse group of leaders within a community. In this study, I will be collecting data from representatives of different health and non-health related agencies in LV.

The Community: LV

LV is formally known as South Lawndale. According to the 2000 census, 83% of its residents were Latino and almost 8 out of 10 were of Mexican descent, and 48% are immigrants (Shah & Whitman, 2005). LV ranks 23rd poorest out of the 77 Chicago community areas, with two-thirds of its population living in poverty (City of Chicago, 2003). Consequently, LV is most

commonly known for the social problems that plague the community as gang related violence, teenage pregnancy, and high school dropout rates (Chicago Department of Public Health [CDPH], 2006; City of Chicago, 2003; Friedman, 2007; Sinai Urban Institute, 2001; Spergel, 2007). The Cook County Jail and the City of Chicago's House of Corrections are also housed in the neighborhood (Reed, 2004).

LV's health care resources include community-, public-, and school-based health centers (CDPH, 2006). Three of the clinics in LV have been documented to engage in work to reduce breast and cervical cancer disparities (About ACCESS, 2010). In 1997, ACCESS community health centers began to outreach low-income uninsured Latina women in different communities providing bilingual and bicultural education on early detection by collaborating with local churches (Shapiro et al., 2006). Unfortunately, data on mammography and Pap smear screening participation rates of Mexican immigrants living in LV is unavailable from ACCESS or other clinics in the community. It is important to note that out of a dozen primary care community health centers in the community, the utilization rates more than double the capacity rates for three of the health facilities (CDPH).

LV has unique socio-historic conditions that are important to note in the present study's examination of the effect of place on health behaviors. For instance, LV is within Chicago, a city that contains the second largest urban concentration of Mexican settlement in the country, with a large proportion of immigrants (46.5%) (Genova & Ramos-Zayas, 2003). In particular, the southwest side of the city, which encompasses LV and Pilsen, an adjacent Mexican American neighborhood, are considered historically "Mexican" communities in the city. This in part can be attributed to the distinctive history of Mexican migrant settlement in this part of the city (Genova & Ramos-Zayas). In particular, between 1960 and 1980 the Mexican population in Pilsen and LV

skyrocketed (Caruso & Camacho, 1985, quoted in Genova & Ramos-Zayas). Despite the long history of migration to Chicago, Mexican immigrants have endured community displacement due to urban renewal and segregation. Briefly, throughout the 1950s Mexican immigrants living in the Near West Side neighborhood were displaced into the Pilsen neighborhood, and eventually further west into what is now the LV community (Genova & Ramos- Zayas).

In addition to early Mexican settlement in Chicago, there is also a history of strong of community organizations, activism among residents, and community solidarity among Mexicans living in the LV and Pilsen communities (Friedman, 2004; Gellman, 2004). According to Genova and Ramos-Zayas, “In Pilsen and Little Village, the heritage of Mexican political mobilization has not only left a legacy of well established community-based organizations, but also educational and cultural institutions and a variety of public symbols that provide testament to the production of these spaces as distinctively ‘Mexican’” (p. 42, 2003). For example, widespread discrimination and police violence lead to the establishment of community-based organizations to defend Mexican immigrants’ legal rights as early as the 1920s (Rosales, 1999). Moreover, the mid-1970s has been characterized as a period of “unprecedented Mexican political mobilization,” with Pilsen being the center of the efforts focused on improving public services, education, and housing (Caruso & Camacho, 1985, quoted in Genova & Ramos- Zayas).

Today LV is a vibrant neighborhood with a successful business strip- *Calle Mexico* or 26th street (McCarron, 2004). Along Marshall Boulevard, one can find *Paseo de los Grandes de Mexico*, or Plaza of Great Mexicans, which consists of a series of statutes of prominent figures in Mexican history (Genova & Ramos-Zayas, 2003). It is estimated that approximately 1,600 businesses, including restaurants, shops, and banks are located along 22nd and 26th Streets (Reed, 2004). LV also hosts the largest annual Mexican Independence Day parades in the state,

drawing hundreds of thousands of spectators from all over city. Other signs of the neighborhood's ethnic pride are reflected in the public monuments, street murals, religious processions, and festivals that take place through the year in LV (Genova & Ramos-Zayas). Moreover, LV residents and community-based organizations continue to be recognized for their activism and organizing, most notably on issues of education. In 2001, a group of LV mothers working with a community-based organization successfully improved educational options of students in the community (Friedman, 2007). A group of community members, predominately mother and grandmothers staged a 19- day hunger strike to demand the Chicago Board of Education reallocate of funding to LV to allow for the construction of a new high school (Friedman).

In light of the complex factors that determine Latina women's screening behaviors, in the present study I use a mixed methods design to uncover the association between community level factors and breast and cervical cancer screening practices among Mexican immigrant women living in the LV community in Chicago. Specifically, the research questions guiding the present study are:

- 1) What are the breast and cervical cancer screening rates of Mexican immigrant women living in LV?
- 2) What is the context influencing women's breast and cervical cancer screening behaviors?
 - a) How do the factors at each of the different levels of the EM influence mammography and Pap smear screening behaviors?
 - b) What is LV's level of readiness to increase screening adherence?

In the first phase of the study, I conducted an exploratory quantitative study to (a) examine women's knowledge, beliefs, attitudes, and emotions regarding breast and cervical cancers, their

risk factors, symptoms, and prognosis, and (b) assess women's screening behaviors. In the second phase, I administered the Community Readiness Assessment (CRA) to conduct a qualitative examination of community factors that influence the screening practices of women in the community. Details about the methodology are provided in the next chapter.

CHAPTER 3

Methods

Research Design

I used a mixed-methods design to examine the influence of community factors on cancer screening participation among immigrant Mexican women in LV. This methodology is particularly advantageous in health research, as health behaviors are complex phenomena and their examination requires multiple data perspectives (Baum, 1995). A mixed method approach allows the researcher to better understand, interpret, and contextualize the experiences of participants (Green & Caracelli, 2003; Patton, 2002). Thus, this methodology is well suited to bring to light the multiple influences on Latina immigrants' health behavior, an understudied area (Krieger et al., 2009). In addition, qualitative and quantitative approaches are crucial to investigating and addressing inequalities in cancer (Krieger et al.).

A mixed methodology is also consistent with an ecological framework. The Ecological Model focuses on understanding the complex and interwoven relations between an individual's behavior and his or her environment (Bronfenbrenner, 1979). Similarly, a mixed-method approach is consistent with the CRM, as it allows the researcher to focus on the participants' social and cultural contexts. Given the complementary nature of a mixed design, the in-depth qualitative portion can be used to clarify and illustrate the results from the quantitative phase of the study (Green & Caracelli, 2003). Therefore, in the current study, the combination of a quantitative and qualitative approach allows for a rich understanding of the multi-level factors that influence screening behaviors, consistent with the theoretical framework used in the investigation.

Finally, a mixed methodology was adopted because a qualitative strategy was needed to examine and understand the unexpected results from the quantitative phase (Morse, 2003). The mixed method approach consists of several stances regarding the mixing of paradigms and mixing methods (Teddle & Tashakkori, 2003). The current study used the complementary strengths stance because the qualitative and quantitative methods were mixed but kept separate to maintain the strength and integrity of each paradigm (Brewer, & Hunter, 1989). Additionally, I used a mixed methods approach for the purpose of triangulation because the combination of results from the two phases provides a more comprehensive picture of the results (Goffman, 1989).

Thus, this investigation was conducted in two phases, first a quantitative and then a qualitative phase. I will first describe Phase I of the study conducted in June and July of 2006. This quantitative phase revealed high mammography and Pap smear screening participation rates among Mexican immigrant women living in Little Village. Inspired by the high degree of screening adherence uncovered in Phase I, I set out to understand in greater depth the factors that could be accounting for this finding. Thus, in the second phase of the study, the qualitative portion, I examined community factors that influence the high screening participation rates among women living in LV through a community readiness assessment. This phase was conducted in July and August of 2010.

Phase I

Participants.

To participate in the study, participants had to be born in Mexico, ages 18 to 65, have no history of breast or cervical cancer, and reside in LV. A total of 41 Mexican immigrant women living in LV participated in the study. Their ages ranged from 18 to 64 ($M = 38$, $SD = 8.68$).

Despite the fact that most women were married (75%) they had low household incomes. For example, 50% had an annual household income of less than \$20,000. Their incomes were consistent with their health insurance status, educational, and acculturation levels; 46% reported being uninsured, 41% had 12 years or less years of formal education, and their acculturation levels were very low. The low household incomes, lack of health insurance, and low acculturation levels were evidenced despite the fact that almost 4 in 10 women (39%) reported living in the U.S. between 11 and 20 years.

Measures.

Socio-demographic and Health Questionnaire. This questionnaire was developed by Professor Lydia P. Buki and Marcela Garcés, M.D. and has been previously used to document the breast and cervical cancer screening practices of Latina women in Central Illinois (Buki, Mayfield, & Andrade, 2011). The 62-item questionnaire (see Appendix A) inquires about women's socio-demographic status, screening behaviors, cultural health beliefs, knowledge about breast and cervical cancer, and access to health care. It is available in English and Spanish and includes both closed- and open-ended questions.

Specifically, the questionnaire included 10 items inquiring about the participants' socio-demographic characteristics including age, racial and ethnic identity, place of birth, marital status, number of children, employment, level of formal education, insurance status, and household income. Items about screening behavior included whether a respondent ever had a clinical breast exam, breast self exam, mammogram, or Pap smear, time since their last mammography and Pap smear screening exam, and the reason for obtaining the exam. To inquire about the women's awareness of screening guidelines and motivators for screening, the questionnaire used closed-ended questions. Examples of the questions included are: "How often

should a healthy woman your age have a Pap smear?” “How often should a healthy woman your age have a mammography exam?” and “Why did you have your last mammogram?” To measure knowledge about breast and cervical cancer detection, etiology, and diagnostic exams, the questionnaire used a 9-point Likert-type scale. Examples of the questions include: “A healthy woman your age should get a Pap smear only when she has a gynecological problem” and “A healthy woman could suffer from breast cancer after being hit in her breast.” The response options range from 1 (*completely agree*) to 9 (*completely disagree*); some questions were reverse coded to improve validity. The last section of the questionnaire inquired about the participants’ access to health care services. It included three items about the type of mass media women draw from to obtain information about women’s health care, their preference in language to obtain the information, and their barriers to obtaining care. Finally, the questionnaire also included open-ended questions that provided women the opportunity to share their beliefs on traditional ways to help prevent cervical cancer and whether family members played a role in encouraging them to have a Pap smear or mammography.

Acculturation Scale. A shortened, 5-item version of the Acculturation Rating Scale for Mexican Americans (ARSMA; Cuéllar, Harris, & Jasso, 1980) was administered to assess participants’ level of acculturation. Items on the scale ask for information about language preference, current circle of friends, and pride in ethnic background. Responses range from 1 (*lowest level of acculturation*) to 5 (*highest level of acculturation*). In previous studies, the ARSMA has yielded an alpha reliability of .80 (Cuéllar, Harris, & Jasso). Additionally, this scale has previously been used with Mexican and other Latina women in breast and cervical cancer studies (Borrayo, Thomas, Lawsins, 2004; Borrayo & Jenkins, 2001; Buki, Borrayo, Feigal, &

Carrillo, 2004), yielding reliabilities ranging from .70 to .92. The reliability for the present administration was .72.

Procedure.

After obtaining approval from the Institutional Review Board from the University of Illinois, I began the recruitment process. Participants were recruited at churches, hair salons, and community centers in an attempt to achieve a broad sample. I elicited the help of community gatekeepers at various community outlets to help identify women eligible for the study. Community gatekeepers are defined as trusted individuals in a community which can include Latino advocates, organization representatives, or church leaders. The community gatekeepers were asked to share the study's recruitment script with general information about the study with prospective participants (see Appendix B). The flyer outlined the purpose of the study and participation requirements, and provided contact information for the principal investigator. I also asked community gatekeepers to obtain the name and phone number of the women who expressed interest in participating so that I could follow up with them about their participation. This information was handed to me in person, and twice via the telephone when a personal meeting could not be scheduled between me and the gatekeeper.

Subsequently, I contacted potential participants by phone to confirm their interest in participating in the study and to screen them to ensure they met inclusion and exclusion criteria. I invited eligible women to participate in the study and scheduled a meeting for them to take the survey at a comfortable and quiet place of their choice (e.g., home, church room). The majority of women ($n = 33$) took the survey individually; a small group of women ($n = 8$) from a community center took the survey as a group prior to a meeting they were attending.

At the scheduled meeting, I told the women that (a) participation was strictly voluntary and confidential, (b) no identifying information would be requested, (c) they would have the choice of not answering any questions or to discontinue participation in the study at any time without penalty or loss of benefits to which they are otherwise entitled, and (d) the questionnaire would take about 20 minutes to complete. Participants completed the questionnaire in the language of their choice. With the exception of one woman, all participants filled out the questionnaire in Spanish. Also, if any of the women had difficulty reading the questions due to low levels of formal education, I read the questions aloud and recorded their answers. At the end of data collection, I provided participants with a resource list that included contact information for the Illinois Breast and Cervical Cancer Program, an initiative that offers free mammograms, breast exams, pelvic exams and Pap tests to low income, uninsured women living in the state of Illinois.

Data Analysis.

Once the data were collected, information from the questionnaires was entered into a data file using the Statistical Package for the Social Sciences (SPSS). Descriptive statistics were obtained for socio-demographic variables. Correlation coefficients were obtained to assess the degree of association between screening participation for each exam and level of acculturation, formal education, and income.

Phase II

Participants.

I conducted a total of 9 interviews, 6 with organization representatives and 3 with women who reside in the community (i.e., community representatives). Organization representatives were defined as individuals over the age of 18 who are knowledgeable about the

community and interface with Mexican immigrant women as part of their employment in health- and non-health related organizations located in Little Village. All organizational representatives were female, ages 24 to 49 ($M = 38$, $SD = 9.33$). They reported working in the LV community from 2 to 20 years ($M = 10.16$, $SD = 8.03$). Additionally, 4 of the 6 organization representatives lived in LV. To ensure that multiple perspectives were represented, I interviewed representatives from the following groups: two individuals who worked in health care service provision; one individual who provided health advocacy, referral, and educational services; and three who worked in non-health-related programs targeted to women. Organization representatives from the non-health-related programs included one from a church-related group and two from women's advocacy organizations. Additionally, I interviewed 3 female community representatives whose ages ranged from 53 to 55 ($M = 54.66$, $SD = 1.52$), and the number of years they had lived in LV ranged from 11 to 26 years, ($M = 21.66$, $SD = 9.29$).

Measures.

Community Readiness Assessment (CRA). The purpose of the CRA is to assess a community's readiness to address a specific health issue. It is administered in a semi-structured interview format, and measures readiness through six dimensions including: (a) community efforts, (b) community knowledge of the efforts, (c) leadership, (d) community climate, (e) community knowledge about the issue, and (f) resources related to the issue (Plested et al., 2006). The original CRA consists of 36 questions in total: 20 core items and optional questions for the researcher to choose the most relevant to the issue and community being investigated. As recommended by the authors, I chose relevant items and reworded them to make breast and cervical cancer screening the focus, and LV the location of interest.

The current CRA has 31 open-ended questions. The beginning of the CRA includes 7 items that inquire about the participants' age, ethnicity, position in the organization they are representing, length of time they have worked for the organization, and length and extent of involvement with the Latino community in general and within LV in particular. In addition, community representatives were asked how long they had been living in LV. To elicit rich descriptive details from the participants, I included a few sub-questions as probes. For example, along with asking "Would there be any segments of the community for which these programs/services may appear inaccessible?", I probed for specific populations "undocumented, monolingual Spanish speakers, older/younger women?", and for ease of access "do the programs serve all immigrant Mexican women equally?"

To elicit information specifically about Little Village's efforts to promote breast and cervical cancer screening, I added 6 questions to the original CRA (see Appendix C). Examples of the questions added are: "Do you think that the leadership in LV makes breast and cervical cancer screening efforts (including programs, services, and outreach) unique from those found in other Latino/immigrant communities? Please explain," and "Compared to other health issues (e.g., diabetes, heart problems) to what extent are breast and cervical cancer screenings a priority in Little Village?. These questions were developed to obtain a deeper understanding of the community factors in place in LV that contributed to the higher screening rates.

The CRA has been used to examine wide array of health prevention efforts among diverse populations, including breast health among Latina women (Borrayo, 2009). The scale authors suggest that four or five key informants are deemed enough for proper assessment of the community's readiness (Edwards et al. 2000). In the present study, I interviewed 6 community leaders (P1-P3, P4, P6, and P9) and 3 women living in the community (P5, P7, and P8) to

capture a more in-depth, broad perspective on screening resources in the community. The CRA was available in both in English and Spanish. The CRA has been previously translated into Spanish; however, for the present study the measure was revised to ensure the high quality of the translation. For example, some words were changed and sentence construction edited to make the text more clear and readable for a Spanish speaking audience.

Procedure.

I recruited participants using a convenience and snowball sampling technique. First, I consulted the world wide web to obtain a list of all the health and social service organizations located in Little Village. Participants selected were representatives from agencies and organizations that provide a direct service to women (e.g., church-related and women's advocacy groups) or work on issues related to health (e.g., health care providers, health program coordinators). The order of the agencies within the list was prioritized based on their relevance to the project (i.e., organizations with a focus on breast or cervical cancer outreach, education, or screening were given priority).

After the list was compiled, I identified prospective participants from within each agency (i.e., the director or coordinator of the program serving Mexican immigrant women) and contacted them going down the list. If the individual initially identified indicated that another staff member within the organization was more knowledgeable about the issue or worked more closely with women in the community, I followed up with that referral. Thus, I contacted a total of 25 individuals representing 15 organizations via phone and email.

Community representatives for the study were recruited in a similar fashion. Organization representatives enthusiastic about the study were asked to identify community women eligible for the study. The organization representative was asked to give a flyer with general information

about the study to prospective participants. The flyer outlined the purpose of the study, participation requirements, and provided contact information for the P.I. Organization representatives were also asked to obtain the name and phone number of the women who expressed interest in participating in order to follow-up with them about their participation.

The ‘snowball sampling’ aspect of the study included following up on any possible referrals from individuals contacted until 8-10 prospective participants were identified. These individuals received on average 3 phone calls or emails. In the first contact, individuals who expressed interest in participating in the study were informed about its purpose following a recruitment script (see Appendix B). For those who agreed to participate, a second contact was made to schedule an interview date and time at a quiet location of their choice (e.g., home, office). The third contact was made to remind the participant about the scheduled interview.

On the date of the individual interview, I explained to participants the purpose of the study and reviewed the informed consent form (see Appendix D). Once informed consent was obtained, I administered the CRA in the preferred language of the participant, English ($n = 4$) or Spanish ($n = 5$). Each interview lasted approximately 60 minutes (range = 45 to 105 minutes). All interviews were audio taped using two different tape recorders to ensure that no data were lost. The first name of participants was used during the taping and later replaced with a participant number in the transcript to protect the participants’ and the organizations’ identity. There was no way to associate the number assigned to each participant to her identity or that of the employing organization. Each of the interviews was initially transcribed by a bilingual research assistant and later reviewed by me as the lead researcher. In this process, I made minor changes to the transcripts to correct grammatical errors and typos. I also went back and re-listened to some of the interviews to fill in parts that the transcriber had marked as inaudible.

During this time, I also wrote down comments on my overall impressions of the interviews and any other relevant thoughts (e.g., recurring names, programs, or themes).

Data Analysis.

Data analysis consisted of two steps: Determining the CRA score and conducting a theme analysis. First, I conducted theme analysis to identify barriers and facilitative factors influencing screening behavior at each of the five ecological levels as outlined by Bronfenbrenner's Ecological Model (Bronfenbrenner, 1977, 1979). Second, to elaborate on these results, I determined Little Village's readiness to address breast and cervical cancer screening. Specifically, I analyzed and scored CRA results using the four-step process recommended in the *Community Readiness Handbook* by Plested et al. (2006).

Theme analysis

I conducted the theme analysis using the methodology outlined by Rubin and Rubin (2005). First, I re-read each interview transcript to become even more familiar with the raw data. In the second stage, *recognition*, I identified concepts, themes, and topic markers (names of places, people, and organizations). Next, I rigorously examined each interview to *clarify* the meaning of different concepts and themes with the aim of *synthesizing* the different perspectives, arriving at my "understanding of the overall narrative" (p. 207, Rubin & Rubin, 2005). Then I physically coded each sentence into the five different levels outlined in Bronfenbrenner's Ecological Model. That is, each sentence was coded as corresponding to one of the following themes: Intrapersonal, interpersonal, institutional/organizational, cultural/community, or public policy (Bronfenbrenner, 1977, 1979). Finally, I *sorted* the data into the 5 different levels on the Ecological Model, and compiled all of the data into a excel spreadsheet to further examine the overall concepts, note any nuances, and examine the data for patterns and linkages between the

various concepts and themes. Finally, I made a list of the main points and created a summary of screening barriers and facilitators identified at each ecological level (Rubin & Rubin).

To avoid missing “original insight” in the data due to this coding method (Rubin & Rubin, 2005), I shared the coded transcript with the second scorer, who acted as an auditor for the theme analysis. Thus, the second scorer re-examined the coding, recommended any changes necessary, and noted personal observations. The changes made included coding an interviewee’s response into another level within the Ecological Model. For example, I had coded an organization representative’s response related to health fairs held at churches and schools as an institutional/organizational level factor; yet, the second scorer argued that it would be best coded under the cultural/community level, as it demonstrated the relations among the different faith-based and health organizations in the community. The statement was coded under cultural/community factor because the main point of the interviewee’s response was the relationships between the organizations in the community, in accordance to Bronfenbrenner’s definition of this level.

CRA Scoring

In accordance with the scoring procedure detailed by the scale authors (Oetting et al. 1995), the scoring process consisted of working with another individual (i.e., second scorer) to independently score each CRA transcript and then jointly reach a consensus on a score for each transcript. The second scorer was a bilingual Latina doctoral student with qualitative research experience that includes firsthand knowledge administering the CRA. To enhance the accuracy of the findings and interpretations, we analyzed the transcripts in their source language (e.g., Spanish, English).

First, we read individually each transcript in its entirety to obtain a general impression from each interview, noting our observations on the margins of the page. We later shared these notes with each other during our discussions to reach a final score for each CRA transcript. Next, still working independently, we used an anchored rating scale to score each dimension in the CRA, per the authors' instructions (Oetting et al., 1995). Specifically, the anchored rating scale lists all of the dimensions in the CRA along with 9 statements for each dimension, reflecting their different possible levels of readiness on a scale from 1 (*lowest level of readiness*) to 9 (*highest level of readiness*). As each of us reviewed the CRA transcript, we linked the interviewees' responses to an anchored statement and assigned a score for that dimension based on the best match between the two. Specifically, we first read the anchored rating scale for each of the dimensions being scored, starting with the first anchored rating statement, and highlighting the interviewee's responses that referred to that anchored statement. If the interviewee's response exceeded the first statement in the anchored rating scale, we proceeded to the next statement, until a statement that reflected the interviewee's response was found. If we were not able to find a matching statement, we stopped searching and determined the level of readiness. Thus, this process was followed for each of the dimensions for each interview. All of the scores were recorded in a scoring sheet similar to that provided by the authors of the measure (Oetting et al.).

After each scorer had completed the independent CRA scoring process for all dimensions of each interview, we met to discuss our independent scores and reach a consensus on the total score for each CRA transcript. To reach a consensus, the second scorer and I meet in person to discuss each CRA transcript and the notes that we had taken while reviewing the interviews individually. If we disagreed about a particular dimension's score, we came to a consensus by reviewing the transcript together and discussing quotes to support the assigned scores. The in –

person meetings also provided the second scorer the opportunity to ask for clarification about an interviewee's response(s). Once we reached a consensus about the CRA score for each interview, I recorded the final scores in a table, and calculated an average score for each dimension by adding all the scores for a given dimension for all interviews and dividing the sum by the total number of interviews. Finally, I calculated the overall stage of community readiness by taking the total of all calculated scores for the dimensions and dividing it by 6 (the total number of dimensions in the CRA). The score obtained from this calculation corresponds to one of the numbered stages described in Table 1 (Plested et al., 2006). Assessing LV's readiness using the CRA helps to further elucidate the importance of place of residence on screening behaviors, as it influences Mexican immigrant women's access to screening information and services.

CHAPTER 4

Results

This chapter is divided into three sections. First, I present the results from Phase I, the quantitative phase of the study. This phase answered my first research question, “What are the breast and cervical cancer screening rates of Mexican immigrant women living in LV?” Results uncovered high breast and cervical cancer screening rates in this population. Thus, next I present results from Phase II, where an in-depth qualitative approach revealed unique facilitative factors contributing to women’s screening participation. In-depth interviews with organization and community representatives pointed to the factors at each of the different levels of the EM that help facilitate and hinder mammography and Pap smear screening behaviors among LV residents. Lastly, I present LV’s “readiness” score to address breast and cervical cancer screening, which provides further insight about the importance of examining place and the complex interactions between individual- and community-level factors influencing women’s screening behavior.

Phase I

Descriptive statistics were calculated for all the main quantitative variables. A total of 41 women participated in the study; information about breast cancer screening behaviors was obtained for 27 of the women (54% of the sample) who were over the age of 40. Despite having lived in the United States for a long period of time, the participants had very low levels of acculturation ($M = 1.30$, $SD = .50$). Almost all of the women (90%) reported speaking and reading Spanish only or Spanish better than English, 70% spent their entire childhood and adolescence in Mexico, 80% reported that all or most of their friends were Latinos, and 70% reported feeling “very proud of being Latina.”

Mammography and Pap smear Screening Practices.

The main finding from Phase I was the participants' reported high rates of screening despite misinformation about breast and cervical cancer and their respective diagnostic exams. For breast care, 79% of all participants reported having had a doctor or nurse perform a clinical breast exam and 87% of women ages 40 and over reported having ever had a mammography. However, rates for repeated clinical breast exams and mammograms were significantly lower than for ever having a mammogram. Only 5% women reported having had a clinical breast exam in the past 5 years, and for mammograms 27% of the women reported having had this exam within the past year, and 11% within the past two years. On average, the women had received 2.8 mammography exams within the past five years ($SD = 1.72$). Most of the women had this exam performed as a part of a routine checkup.

Socio-economic factors played a prominent role in participants' access to and receipt of screening exams. This may be due to the fact that almost half (46.2%) of the women in the sample reported having no health insurance. The most common barriers cited by women were having to wait too long to get an appointment (61%), language barriers communicating with doctors and nurses (30%), being unable to pay for health care services (28%), and not having transportation (20%). However, women in the sample were able to overcome all of these hurdles and reported usually high mammography and Pap smear screening participation.

Similarly, participants in the study reported high cervical cancer screening participation. Almost all women (95%) reported having had a Pap smear at least once in their lives. Repeat screening rates were also high, as 92% of the women reported having their last Pap smear exam within the past two years. Also, 39% of the women reported having had a Pap smear five or more times in the last five years (i.e., they adhered to recommended Pap smear guidelines). On

average, the women had received 3.8 Pap smears within the past five years ($SD = 1.40$). The most commonly cited reason for having had this medical exam was as part of a regular doctor's visit (76%), followed by gynecological problems (10%).

Knowledge about Breast Cancer and Mammography Exams.

Most of the women reported erroneous beliefs and little knowledge about breast cancer and mammography exams. The most significant finding was the participants' high level of misinformation and uncertainty regarding various knowledge statements, especially those regarding screening guidelines, risk factors, and breast cancer etiology. For example, only 53% of the women correctly answered knowing how often a woman should have a mammography, and another 27% reported not knowing or being unsure. Moreover, participants held incorrect beliefs about breast cancer risk factors and causes. For example, 40% reported not knowing or being unsure, and 20% erroneously believed, that younger women are at higher risk of developing breast cancer than older women. Only 12% correctly reported that older women are at higher risk of developing breast cancer than younger women. More than half of the women (56%) did not know or were unsure if they were at risk of developing breast cancer. Almost all women erroneously believed that a woman could develop breast cancer if she got hit in the breast, 46% answer that this was possible and 44% did not know or were unsure.

Knowledge about Cervical Cancer & Pap Smear Exams.

Although virtually all of the women reported having had a Pap smear exam at least once in their lives, their knowledge about cervical cancer was relatively low, with the exception of knowing the recommended screening guidelines. For example, 88% of the women reported being knowledgeable about Pap smear screening guidelines and knew that a woman should obtain a Pap smear screening every year. This information is in line with the ACS recommendations

(ACS, 2009). Yet, participants in the sample still had many misconceptions about cervical cancer risk factors and causes. For example, 1 out of 5 women believed that a Pap smear is needed only when there is a gynecological problem, and almost half of the women believed a Pap smear is needed only if their doctor recommends it. Half of the women (51%) endorsed not knowing or being unsure of their risk of developing this disease. In contrast, 18% of the women believed they were at high risk for having cervical cancer.

Phase II

Intrapersonal and Interpersonal Factors

Mexican immigrant women living in LV reported that multiple intrapersonal factors combine to act as barriers to obtaining breast and cervical screening exams. However, these factors often intersected with other level issues, highlighting the complex interaction between individual, community, and policy level influencing a woman's screening behavior. For example, participants reported that the combination of the cost of obtaining medical care, their work schedules, family responsibilities, and lack of information about the importance of screening and resources available all contribute to women not prioritizing required screenings. Interviewees also emphasized that women in LV typically work for hourly wages and experience difficulty accessing medical care in general. Consequently, obtaining routine preventive care such as screening exams presented many financial and time constraints for women. As two organization representatives reported:

P3: So, let's say you have a job and you're going to leave a day of work to go take care of your annual [exams]. It's not going to happen, it's not going to happen knowing that the fear is there that there are ten women behind [you] willing to take this factory job....if you are trying to put food on the table, you are not going to go get your pap smear...

P4: Just for [Mexican immigrant] mothers to prioritize themselves is hard to do, you know? What...are [their] future goals? Many times it has nothing to do with [prioritizing themselves], they may be getting [their] children to college, buying a house for [their] children, but it's never to obtain an education or get better healthcare for...themselves. [They] are always on the bottom of the list.

Thus, Mexican immigrant women working in the service industry not only have limited flexibility with their work schedules, but they are also at risk of being replaced with another employee if they miss work for a day or even a few hours. Such time and financial constraints are prohibitive to community women who may not be informed about the importance of early detection.

Knowledge about Breast Cancer and Mammography Exams.

Participants reported that women in LV only have basic knowledge about breast cancer and the importance of mammography exams. A coordinator of a cancer outreach program in LV reported that even women who obtain screenings regularly have little knowledge about breast cancer risk factors:

P1: Well, in reality, they know very little. The majority of women who get seen know they have to get checked but they don't know specifically what breast cancer is....who can get breast cancer, what is the greatest risk factor in getting breast cancer, and all the warning [signs] that women should know if they get breast cancer...the majority doesn't know.

Organization representatives noted that family, friends, and neighbors promulgate misinformation about when and who should receive a mammography exam. Consistent with this observation, community representatives held inaccurate information about mammography screening guidelines, including at what age women should start obtaining this medical exam.

Unaware of the screening guidelines herself, a community representative believed that her neighbors, who were younger than 40 years old, should be obtaining mammography screenings:.

P9: For example, I have my neighbors whose daughters live with them, they are 30 [years old], and they have never had one [a mammography]. [They say] ‘Oh, not my daughter, she doesn’t have kids. She’s never been married, never...She doesn’t need a mammography; she doesn’t need anything.’

The exchange of health information among family members and friends sometimes arises out of someone’s negative experience with the health care system, such as when receiving treatment for breast cancer. A staff member at a community clinic described how hearing about this type of experience may negatively impact a woman’s decision to screen:

P3: Also, some of the barriers that I’ve heard are just around breast cancer. Just horrific stories of grandmas and aunties that were detected and were just dying, and you know they probably didn’t get the treatment that they needed. So [women who heard about this] felt fear [of obtaining a mammography exam]. It’s sometimes them not wanting to know or something they didn’t want to look at, because they’ve experienced people who have had [breast cancer] but didn’t have adequate treatment and the suffering...

In this story, the inadequate medical care of a family member negatively influenced the screening adherence of a woman in need of a mammogram. The organization representative thought that if women in the community understood the importance of early detection and how screening improves a woman’s treatment options, they may be less influenced when hearing about a relative’s negative experience. Thus, to address this situation, organization representatives suggested implementing multi-generational education efforts that include grandmothers, mothers, and daughters being exposed to cancer information.

Knowledge about Cervical Cancer and Pap smear Exams.

Participants also reported that women in the community are misinformed about cervical cancer. Specifically, they noted that community women hold erroneous beliefs about this cancer's risk factors and causes. Women's lack of information about Pap smears as a preventive exam to test for cervical cancer leaves them without an understanding of the importance of obtaining this medical exam on a regular basis. Participants also reported that erroneous cultural beliefs play a prominent role in women's low risk perceptions and subsequent lack of Pap smear screening.

Organization representatives reported that cervical cancer is a difficult and even taboo subject to discuss openly in Mexican families. Participants believed that cervical cancer is a taboo subject because it deals with Mexican women's sexual activity, partners, and history. This taboo, coupled with the lack of information about the importance of early detection, place some women at higher risk of not adhering to screening recommendations. For example, one organization representative worried that a monogamous working mother who does not know the importance of early detection and only associates Pap smear screening with promiscuous sexual behavior (i.e., having multiple sex partners), has a high probability of not obtaining a Pap smear exam. Consequently, women in LV feel "immune" to cervical cancer if they are not engaging in promiscuous behaviors, without understanding that their partners' current or past promiscuous behaviors also places them at risk: "The majority of women do not believe that they are [at risk for cervical cancer] because the majority of them say 'Well, I only have [sex with] my husband.'" (P1) Similarly, a community representative stated: "[Women in the community] think 'I'm never going to get it [cervical cancer]. Why would I get a Pap smear if I don't have kids, and I don't even have a husband anymore, if I am a widow?'" (P5)

Dispelling Misinformation about Breast and Cervical Cancer Screening Exams.

Against this backdrop, which emphasizes the widespread misinformation about breast and cervical cancer and their respective screening exams, organization and community representatives also reported many facilitative factors present in LV. A small but growing portion of female residents have learned about screening resources available and have been exposed to education about the importance of early detection. Women who are active participants in faith-based and other community organizations are the most likely to be knowledgeable about screening education and services. For example, organization representatives detailed the different ways in which women who are active members of their organizations routinely receive health information and resources through activities such as workshops and community fairs.

Participants reported that these groups of women subsequently share the information they learn with family, friends, and neighbors, some of whom may not be as involved in the community. For example, a community representative who had worked at a local laundromat for over 20 years recounted several instances where women would ask her questions about access to services because they trusted her and sought her guidance to access health services. Women's social networks, then, allow them to connect with other women, share health information, and even help other women navigate the health care system. For example, another community representative had knowledge about the health care system such as the ability to pay later or ask for payment plans, which could ease financial costs related to obtaining screening exams. This representative subsequently shared this information with family and friends:

P7: I tell them [women in the community]: ‘If you do not have money, you can go get the exam. They will charge you later, and you have time to see how you will pay. They [clinic staff] will not demand payment in full. They can give you a payment plan.’

Participants reported that women in LV also share information about how to navigate the health care system and how to access social services in the community. Unlike the misinformation and myths shared about cancer and screening exams previously described, participants regarded the information-sharing process about health services available and how to navigate the local health system as positive community factors. Both organization and community representatives felt that this practice was helpful and instrumental, especially for recent immigrants and women who had recently moved to LV. However, organization representatives repeatedly mentioned the importance and need for additional education efforts to combat the misinformation about breast and cervical cancer and screening exams.

Institutional and Organizational Factors

All of the interviewees’ responses underscored the different ways in which LV’s health care system infrastructure negatively influences women’s access to screening resources. First, all participants reported that LV’s health resources are limited in comparison to those available in other areas of the city. Organization representatives talked at length about the lack of access to preventive care in the community. Although LV has eleven primary health care centers, participants described the local health care system as overburdened and unable to adequately meet community needs. Thus, screening resources were also perceived as inadequate:

P6: I would say that a lot of funds go to things that have nothing to do with healthcare... If they had more funds for healthcare like, for example, if [we] had more community health

workers...we would have more people [getting] screened and that would probably change the [screening rates].

Both organization and community representatives indicated that free or low-cost screening resources are available but limited in LV. As a result, women experience various difficulties accessing the exams. For example, participants shared stories of women who show up for their appointments and leave before seeing a health care provider due to long waiting times. Community representatives also reported that women in the community are discouraged from obtaining screenings by having to wait up to 2 months for an appointment, a time period that may lead some women to forget about their exam. Another organization representative shared her frustration about insufficient screening resources available in LV. The participant's organization was referring women in need of screenings to a local clinic; however, the women were turned away due to a lack of available appointment slots.

The strain experienced by health care facilities also compromise the quality of care received by patients. For example, a community representative reported not being able to ask her doctor questions about the care she was receiving because of the doctor's time constraints: "The [doctor] would not let me ask anything, because [he] had so many patients [waiting to be seen] after me--a ton of people!" (P5). This community representative perceived the low quality of care received at community clinics as a barrier to obtaining routine medical exams. In particular, participants alluded to the local health care system's limited capacity and staff to serve LV's resident population. The following quote by a community participant demonstrates the effects of poor quality of care from the patient's perspective:

P8: Well, if the staff was a little more accessible [women would use health care services], because sometimes people will ask [the staff] something, and since they are overwhelmed

with work, they answer harshly. And the people... get scared and don't want to return.

Because what if you ask me something and I will answer harshly or ignore you? Would you want to come see me again? Well, no. That is why I think that people don't go, because they are not treated with dignity, they are denigrated...

Finally, participants reported a dearth of specialty care in LV. Organization representatives noted that, in relation to the size of the population in LV, health care resources are limited. Services available are primary care facilities, which typically do not provide follow-up care for women with abnormal test results. Therefore, women who are diagnosed with cancer have to receive treatment in health facilities located outside of the community. Community representatives indicated, as well, that there is a shortage of health care providers in the community.

Similar to women not prioritizing their health at the individual level, one organization representative felt that LV does not give priority to women's health issues. Not being a priority, there are insufficient health resources in LV to address the residents' needs, which translate into additional personal barriers for women in the community. A participant who coordinates the social services at a local church provided insight into how women from the community interpret the limited health resources available in LV:

P9: Here in LV we have very few services, and they give us [Mexican immigrant women] very little [priority], especially as it relates to women's health... Here, there are no [women's health services offered], we don't have any information...I don't understand why they don't offer us [women's health] services...

Organization representatives especially emphasized the challenges in obtaining affordable follow-up screenings and treatment for breast and cervical cancer. Community representatives

indicated health care services located outside LV are inaccessible due to the fact that women may not be familiar with other parts of the city. Transportation is a significant obstacle for women in LV who may not have a car, may not know how to drive, or are unfamiliar with the transportation system outside of the community.

Organization representatives spoke at length about the facilitative factors present in LV which help community women navigate and access screening services despite the unfamiliar and cumbersome health care system. Organizations and institutions in LV work to educate, encourage, and streamline the process to obtain screening exams. LV has several local-level and informal policies to effectively address issues of language access. As a result, language barriers are not seen as a primary concern within the community: “The expectation from the patient when they come through the door [of the clinic] is that [clinic staff] are going to speak my language” (P3). Similarly, another participant noted that institutions and organizations identify strongly with the community’s Mexican, bilingual, bicultural identity: “I think for the most part our community is so bilingual that Spanish is a must when you hire someone [to work in a community organization]... so I don’t know if that’s a barrier itself.” (P4)

Consistent with the organization representatives’ views, a community representative spoke at length about her ability to choose a female Spanish-speaking provider. Similarly, an organization representative reported that the availability of Spanish speaking providers and educational programs in LV made the community women feel comfortable and not discriminated, “they feel like they are in Mexico” (P6). In contrast, participants reported that women frequently have negative experiences when they need an interpreter at a large public hospital in another part of the city. All community representatives, in fact, reported having

received medical care in health care facilities located in other parts of the city that had much more limited language access compared to that available in LV.

LV also excels in providing information about early detection information to women in the community. Participants described the different screening-related information, referral, and advocacy services provided by health facilities, community organizations, and faith-based organizations in LV. Organization representatives consider this type of support and assistance extremely valuable for recent immigrants in the community, especially for those who have not yet learned how to navigate the health care system and access services. However, they also recognized that the practices and efforts of LV's institutions and organizations are not the standard but rather an exception. They compared LV to other communities with significant Mexican immigrant populations, and reported that these other communities did not have as strong a focus on delivering culturally and linguistically medical care to residents as LV:

P6: I lived in [name of suburb] and if you don't have insurance over there, you are kind of in trouble because they don't have [educational outreach] programs like [LV] over there.

Actually, we have patients who come from [name of suburb in Chicago] which is 45 minutes away so that goes to show you [the limited availability of low cost health care services elsewhere]...

Other participants agreed that LV's low cost services are used by women who travel from other communities in the city and the suburbs. Community representatives reported having family members and friends who were among those patients traveling to LV to access medical care at the local clinics because they are affordable and offer bilingual providers.

Finally, the clinics' geographic location is a facilitative factor mentioned by all the participants. One community representative shared that she became a patient at one of the local

clinics because it was located one block away from where she was living. Two organization representatives employed at different clinics also acknowledged that the central location of the clinics helped attract patients. Specifically, they reported that the location was important because it was a comfortable and familiar place for patients:

P3: Well, I think one of the benefits for [name of the clinic] is that we are on [centrally located street]. So I mean, you know, yeah, a lot of our women don't drive... I think the other thing that is very good about our location and [clinic X's] location is we very much are inside the arches [laughs]. I mean this is seen as the downtown of our community... I mean everybody knows [name of street]. You know it's walking distance... I think the location of this clinic is very special. It's [near popular places visited by women in the community]...

Findings from this section underscore the strong sense of community pride exhibited by the organizations and institutions located in LV: “We are the exception of different communities in Latino communities across the country. I think we are very fortunate to have all the services that we do and it comes from activism. These are communities that are built on activism” (P 2).

Cultural and Community Factors

Participants cited social problems such as poverty, gang violence, and other health conditions, such as diabetes, taking prominence over breast and cervical cancer screening. In particular, organization representatives pointed to the social, political, and economic conditions in LV and their deleterious influence on community members' participation in medical services. Their concerns are not unwarranted: LV is a working-class community with high poverty rates, violence (domestic and gang related), and a troubled school system (Chicago Community, 2001, 2006; City of Chicago, 2003; Friedman, 2007; Spergel, 2007). Therefore, breast and cervical cancer screening takes a back step to other more prominent social problems like gang violence.

Two participants indicated that even though LV is disproportionately affected by chronic conditions and illnesses, attending to violence is a more immediate priority in the community:

P4: I think that [gang-related violence] takes a lot of the resources...trying to prevent gang violence in the community. I am not sure where healthcare ends up on that list of resources in the community. I think it should be one of the top ones, [but] when you have immigration [and] violence, where does healthcare really end up? I am not certain....

P2: I think [health] continues to be on the lower end [of priorities] compared to violence in our communities, even though [health] is major concern in our community when you look at diabetes, chronic illnesses, and heart disease. I think that when you talk to a parent, he or she is more concerned for the safety of their child not being victim of a crime when he or she comes from school [than about a potential health care issue].

Additionally, organization representatives noted that the current xenophobic political environment, anti-immigrant sentiment, violence against immigrants, and recent immigration raids engender fear in undocumented immigrants, further acting as a barrier to health care access:

P3: I think that the community again is going through [a] different [time], this is not the immigrant community [it once was] and this is not the danger that we thought it was...In the last 3 months....I know countless people who ended [up] being deported who are not... trouble makers. They are not who ICE [Immigration and Custom Enforcement] says they are deporting. And so I'm hearing that more and more, when people come [in for their appointment], some of them talk about [providing information about their immigration status], when before, for many years, there wasn't much question about 'Where is this information going?' You know, it's starting to happen more, and so to me that is always a clue that people

are being more careful and understandably so. [They are being more careful] about where they go and who they fear.

Organization and community representatives also perceived that the community's strong Catholic and culturally traditional values result in women being reluctant to discuss early detection in public spaces. The following quote demonstrates the intersection of religion and discourses of breast and cervical cancer and their respective screening exams:

P2: I think there is still a major taboo to talk about cervical cancer even if you get information... *Siquiera* [at least] — you can talk a little bit about breast cancer... It's a little more acceptable to speak about [breast cancer] because...you could have never [had] sex in your life, you could be a virgin and get breast cancer, right? But [for] cervical cancer there is HPV associated with it so there is this wall....You don't talk about sex. Sex is rarely spoken about in Mexican households...It makes it that much more difficult to [talk] to people about the importance of screening in the community... it's just another layer.

In addition to the absence of discussions about breast and cervical cancer in the public sphere, participants noted that cultural and religious values also hamper some of the existing early detection efforts. One organizational representative reported that breast and cervical cancer educational outreach programs sometimes have to be censored when conducted in churches to avoid topics of sex, sexuality, birth control, and contraceptive use.

Despite the presence of barriers, participants noted several community-level factors that positively influence cancer screening participation among women living in LV: their strong sense of community, their high level of resident participation in community events and activities, and their activism related to improving community conditions, including health resources. One organization representative stated the following in response to what makes LV unique:

P3: I think some of it is just geographically; 26th Street has become the main drive, even more so than Pilsen. It [26th Street] really has the feel of its own little downtown.

And it's an [amazing] community [despite] all of the [social] problems, it really is a microcosm within itself, you can find anything on 26th street you want to find. You know you need to get your tires fixed or you need to go to the doctor or the dentist...

In addition to LV being a central location for accessing resources ranging from health services to a mechanic, the quote also points to a sense of pride among LV residents.

Organization representatives reported that the community has a strong sense of responsibility to address the health needs in LV. All participants pointed to the varying levels of commitment among the local health care system, social services, community organizations, in addressing the health needs of the community. They perceived that current community partnerships would support additional screening efforts as well as efforts to address the gap in knowledge to screening services in the community. Moreover, the collaboration between different community and faith-based organizations on current cancer screening efforts indicates their willingness to invest time and resources on this important health issue.

Organization representatives also pointed to residents' social activism as a factor influencing the community's health resources. One organizational representative related a story about an instance in which local women's activism prompted the creation of a breast and cervical cancer outreach program:

P1: Women in churches began to organize because they knew about the high mortality rate for breast cancer for Hispanic women. And given that many women in this community don't have resources, they started to organize. And they took action so that a breast cancer program would have funding....And that is why we have programs such as this....

In fact, interviewees provided several examples of residents and organizations working together to improve the health status of women in the community. For instance, at the time of the interviews a group of women was organizing around immigration issues, given its recognition that being undocumented presents barriers to receiving breast and cervical cancer treatment.

Policy Level Factors

At the policy level, participants pointed to community women's lack of information and their uninsured and immigration status as prominent barriers to accessing screening resources in the community. For example, community representatives reported that lack of information subsequently leads to women's low perceived risk for breast cancer. This low perceived risk, in turn, places women at higher risk of not obtaining routine mammography screenings. The following statement from a community representative shows how lack of information, insurance, and being undocumented are considered the primary barriers to accessing screening services:

P8: Well, I'll repeat it again, information is number one. Number two, that they accept one without health insurance. I imagine that if those barriers are not placed there, we would more easily have access [to breast and cervical cancer screening services]. Number three, that [being] undocumented is not a barrier, because more [important] than anything is one's health. Then, those three factors would make it so one pays more attention to one's health earlier.

The quote also highlights the complexity and intersectionality of the factors influencing Mexican immigrant women's mammography and Pap smear screening participation rates. A woman's socioeconomic, health insurance, and immigration status that have been traditionally considered as intrapersonal factors that render women at risk of not screening; however, they can be most effectively addressed through public policy.

Women's lack of health insurance and undocumented immigration status were recurring policy level barriers mentioned by participants in all interviews. The most cited barrier throughout the interviews was lack of health insurance. Organization representatives noted that despite the practices of community organizations and institutions in LV aimed at reducing or eliminating financial barriers to screening, additional funding for education and services is still desperately needed. Local health clinics offer free or low cost screening services though state funded programs. However, for women who do not know about or do not qualify for these programs the cost of the exams may still be out of reach.

Consistent with this, interviewees noted that in comparison with other ethnic minority women, Latinas are disproportionately represented among those who are undocumented, further acting as a barrier to breast and cervical cancer screenings. For example, a staff member at a community clinic reported:

P6: [Mexican immigrant women] have a little bit more trouble [getting screened than women from other racial/ethnic groups]...they always ask me: 'Does this place charge? Is it free? I don't have a social security number, is that going to affect me?' And then I explain to them there is no problem, nothing is going to happen to you. Everything is going to be fine, it's free, you don't have to have insurance, you don't [need to] have ... a social security [number]... you just have to reassure them.

Also, participants described how the anti-immigrant sentiment nationwide and the recent immigration raids in the community impact LV residents' decisions to seek and access medical care:

P3: I have seen horrific changes in the last year in terms of access because just events happening with ICE and the fear in the community...And so again you can get your screening

and you can get your care for free but even that message [that ICE] is out there...it [women screening] is not going to happen.

Summary

Mexican immigrant women living in LV face significant barriers to breast and cervical cancer screening, yet they are able to overcome them and report high mammography and Pap smear screening rates. Findings from the present study indicate that two prominent barriers to screening adherence are women's limited access to health care and lack of information about the importance of early detection. However, community organizations and health institutions continually work to reduce and at times eliminate these barriers by enhancing accessibility, reducing the cost of exams, and providing services and information in Spanish. In this context, many women access information and obtain needed screenings. To examine in greater depth the ways in which community organizations and social service agencies serve as a buffer to many of the identified barriers, next I present the results from the CRA.

Community Readiness Assessment (CRA)

The calculated scores for each of the six community readiness dimensions are displayed in Table 3. The table shows significant variability across the dimensions. LV exhibits the highest scores for dimensions on community efforts on breast and cervical cancer screening and leadership initiatives to address the issue. The lowest scoring dimensions included knowledge about breast and cervical cancer screening and community knowledge on breast and cervical cancer screening resources. The overall score showed that LV is in the "Preparation" stage to address breast and cervical cancer screening in the community. Consistent with the stage of "preparation," the assessment revealed that: (a) there are ongoing screening programs and services; (b) segments of the population are aware of screening resources; (c) organizations

recognize cancer screening disparities exist among Mexican immigrant women and have taken an active role to ameliorate the issue; and (d) the community would be invested in increasing educational efforts and expanding screening resources. Next, I will be presenting the results of each dimension of the CRA separately.

Dimension A: Community Efforts.

Based on the interviewees' responses, educational programs about breast and cervical cancer have been in existence in LV for a decade. These efforts have been lead by two major groups: medical and community-based organizations. Participants provided several examples of both groups working together to carry out education, outreach, and screening services to women in the community.

Local hospitals and clinics provide free and low cost mammography and Pap smear screenings through state-funded programs such as the IBCCP. Two organization representatives working in separate local clinics described a strong cancer education component both as a part of the care provided to patients through doctor's visits as well as outreach activities. Specifically, these activities are aimed at increasing community women's awareness about early detection through outreach worker programs, the provision of educational information in waiting rooms, and annual events on breast and cervical cancer and the importance of screening. Next, I detail some of the specific programs available in LV.

Outreach Workers and Promotora Programs.

Community clinics and organizations employ "*promotoras*," community outreach workers, to increase awareness about the importance of early detection. *Promotoras* are members of the community who speak the same language and belong to the communities they serve, providing education, advocacy, and outreach to other members of the community (Rhodes,

Foley, Zometa, & Bloom, 2007). *Promotoras* distribute information on the importance of screening exams and provide referrals for free screenings to local clinics for women who need them. Their educational efforts are concentrated in places where women traditionally gather such as churches, food pantries, and beauty salons. Participants reported that *promotoras* have been effective at increasing awareness about the importance of early detection. However, organization representatives acknowledged that they are too few *promotoras* for the size and health needs of LV's population.

Examínate Comadre.

Two participants, one representing a clinic and the other a community organization, discussed their involvement with the Pin-a-Sister Campaign or its equivalent, the *Examínate Comadre* campaign targeting Latina women. Launched in 2007, *Examínate Comadre* is a statewide breast cancer awareness campaign designed to reduce disparities in access to screening and treatment services among African American and Latina women. Its programming is jointly organized by faith-based groups, health care clinics, and community-based organizations. *Examínate Comadre* hosts an annual event on Mother's day at faith-based centers across the state, where cancer survivors share their experience and provide health information on breast cancer and mammography exams to church attendees (Pinasister, 2011).

Miscellaneous programs.

Organizational representatives also reported additional, less organized breast and cervical cancer education and screening efforts taking place in LV. For example, community organizations that do not focus on health report including early detection education components into their regular activities and events. In addition, cancer detection efforts are usually highlighted at community health fairs.

Dimension B: Community Knowledge about the Efforts

All organization representatives were able to name the organizations working on this issue and described the various cancer screening programs and resources available in the community. Participants were also knowledgeable about the health facilities in the community offering free or low cost screening exams (e.g., Access Community Health Network, Alivio Medical Center, Jorge Prieto Family Health Center, and the Lawndale Christian Health Center). In contrast, the lack of knowledge among community representatives about screening and educational programs available in LV was striking. None of the community representatives reported knowing about education efforts, including outreach programs or educational workshops on early detection of breast or cervical cancer.

Interviewees' responses regarding current community efforts inevitably lead to a discussion of insufficient resources in the community. Organizational representatives reported that women in the community experienced difficulty accessing screening services due to the overburdened health care system: "I can tell you the challenge we had with clinic X, was that they have only so many free slots available. So when we started to send more women... [The clinic said] you know we can't afford so many women right?" (P2). Due to the limited number of available screenings, an organization representative shared that she had to scale back the number of referrals given to women for free screenings. The partnering health care clinic was only able to provide a small number of screenings, with an even more limited number of slots available for new patients.

One of the main challenges mentioned by all interviewees was that posed by the limited resources available for women diagnosed with breast or cervical cancer. The vast majority of state and local programs focus on getting women screened but do not include resources for

treatment upon diagnosis. Women with low incomes find themselves in a precarious financial situation when they are forced to pay for cancer treatment. A staff member at a local clinic described the difficulty in finding resources and support for women in need of treatment:

P3: I am trying to help someone access care and manage their feelings and manage their finances...It's helping people with the cost of treatment. And it is tough and a lot of times we have used Catholic Charities' help. And I have used [community organization] and just all of those sort of different sources of calling for help because people start having trouble with rent and having trouble with housing and electric [bills]...It's the pain of the cost of treatment.

Participants reported that a very small proportion of women in the community know about breast and cervical cancer resources, and noted that women know more about screening resources for breast cancer than cervical cancer. Finally, interviewees agreed that finding screening resources is especially challenging for recent immigrants. Women who are already receiving medical care, are more socially connected, have lived in the community for a long time, or are involved with community organizations (i.e., health and non-health related) are more likely to know about and have access to cancer screening resources than women who are more isolated. Women who are better connected receive information about health resources by asking staff at the medical clinics about their health education and screening services offered, and by attending community workshops, events, or activities.

Dimension C: Community Leadership.

There was a consensus among participants that within the LV community, there is not one organization or identifiable individuals who act as leaders in breast and cervical cancer efforts. That is, participants overwhelmingly felt that there are no leaders that specifically address the importance of early detection either through education or provision of services. The

following quote by an organization representative illustrates this point well: “I know that there are people doing the work. So we know what hospitals are doing the work, but who are the champions?I don’t think that we have any champions” (P2). However, participants also indicated that even though there are no leaders specific to the issue, additional breast and cervical cancer screening programs would be supported by key players in LV, such as community organizations and health clinics. In addition, an organization representative reported that a local media news anchor has increased awareness about cervical cancer by becoming the spokesperson for cervical cancer public service announcements. However, breast and cervical cancer efforts are inefficient without a clear leader to coordinate offerings, optimize resources, and minimize duplication of efforts.

Dimension D: Community Climate.

Several aspects of the community climate in LV indicate the existence of a strong foundation and community-wide support to extend current breast and cervical screening resources in the community. The fact that organization representatives show concern and a sense of responsibility suggest that community organizations are invested in increasing cancer screening rates. Moreover, community representatives specifically recommended using local resources to expand current efforts and increase awareness about the importance of early detection. Community organizations, churches, and schools were all seen as potential resources in this effort. Two participants framed access to cancer screening as a community-wide issue in which various resources need to be pooled for efforts to be optimally effective:

P4: I think as community leaders, there is a responsibility on us to educate our community, not just to leave them kind of hanging like here’s the information but you are kind of on your

own...so that's why we try to....bring somebody that they agree to provide not only the information but a service after the workshop is over.

P2: I think that if we are going to have any impact on breast and cervical cancer and getting people to be diagnosed, [it] is a community issue and so when we are talking about community it includes the churches, schools, clinics, it includes community organizations...It's a community issue, as all public health issues should be.

Participants provided many examples of collaborations between health clinics, churches, and non-profit community organizations. Community organizations currently collaborate with each other to increase awareness about the importance of cancer screening and provide referrals for free or low cost screening exams. Even in organizations where health was not a primary focus, participants referenced several examples of outreach events that featured early cancer detection education:

P4: We usually do [workshop on early detection] once a year, through [name of outreach program]. We also partner with [name of local clinic] so [women who participate in the program] actually get information...on breast cancer...So [name of outreach program] come into a session. It's about 2 hours long, they go into what the risks are if it is detected late. Last year...they had a breast cancer survivor. She gave testimony on the importance of get[ing] screened, and at the end [women in the program were] handed referrals [to a free mammography exam].

Likewise, existing collaborations between faith- and community-based organizations suggest that different players in the community engage various constituencies to reach women in the course of their daily lives at institutions that are relevant and important to them. However, these collaborations also present challenges. For example, a representative of a community

organization with a cancer screening outreach program that works closely with a church shared that the workshops hosted at the church were “toned down” to avoid or limit the discussion on topics related to sex and women’s reproductive health. This censorship was especially evident on the topic of cervical cancer risk factors, such as increased risk due to exposure to multiple sex partners, and lower risk through the use of condoms.

Another major concern for participants was the lack of health information about the importance of cancer screening in LV. On the surface level, this “silence” was construed as a lack of interest among the women in the community. However, all participants felt that this climate of disinterest was due to women’s lack of awareness about the importance of early detection because of the scarcity of health information available in the community. Because women were misinformed about the issue, they perceived their risk for developing breast or cervical cancer as low. Most importantly, participants felt that misinformation can and should be tackled with educational efforts that reach all women in the community.

Dimension E: Community Knowledge about the Issue.

Almost all of the participants attested to the general lack of knowledge among community women about breast and cervical cancer and the importance of screening exams. Both organization and community representatives agreed that women in the community have very basic knowledge about the two types of cancer as well as mammography and Pap smear exams. They reported that women’s perceptions about this topic are riddled with myths and misinformation about screening exam guidelines, screening efficacy, cancer risk factors, and treatment options:

P4: I think our community is not well informed [about] what age you should start [screening], what’s the importance of that? I think they come in with a mentality ‘Oh, my mother’s never

had screening and she is fine.’ So, [to them it means] that....they [can] go their whole lives without getting a screening and be fine. So I think that the mentality is wrong.... I think that there is a lack of information [and that we need to better] reach our communities.

In particular, participants reported that community women who did not have a family history of breast cancer perceived not being at risk of developing this type of cancer. Participants also indicated that women are provided with more information about other health conditions, such as diabetes and heart problems, than about breast and cervical cancer.

One notable difference between the two groups of participants is their perceptions about the availability of early detection information in LV. Although all participants agreed that the information provided was insufficient, organization representatives reported that it was readily available, and community representatives indicated it was not easy to find. Moreover, community representatives reported that this information was not even available at community clinics. One participant reported: “If I go to a [local] clinic, are there pamphlets and this and that there? No! Where I have seen the pamphlets on cancer detection of the uterus and of the breast is at the large hospitals [not clinics in LV]” (P5). This participant reported that women in the community would be open and willing to learn new information if it were available.

Organizational representatives also pointed to the media being critical in providing health information about the importance of early detection. For example, they mentioned the breast cancer pink ribbon television campaign as a source of information on the importance of mammography screening. Moreover, a staff member of a cancer outreach program reported that women in the community learn about their screening and referral services mostly through word of mouth and radio. Organization representatives expressed the need for consistent media efforts:

P6: There is [media coverage on breast and cervical cancer] but I don't see it too much.

Usually when I see it when it's cancer awareness [month]...but we don't see it throughout the year. It fades away and then I don't hear it anymore on TV.

However, community representatives did not perceive the health information disseminated through the television, radio, and newspapers as sufficient to inform women about the importance of screening or to motivate them to obtain a mammography or Pap smear exam. Additionally, organization and community representatives noted that the screening information in the media tends to focus one type of cancer but never both. Finally, participants noted that health information provided through the Internet was not accessible, given that places with internet access such as the library are not accessible to the women because there is only one public library in LV, and it only has a few computers available for adults.

Breast Cancer and Mammography Screenings.

Women in LV appear to have more knowledge about breast cancer and mammography than about cervical cancer and Pap smear screenings. A community representative reported that out of the two types of cancers, breast cancer efforts are given higher priority than cervical cancer in the community:

P8: Look, I don't know exactly why it is, what the difference is, but I have seen that they give more priority to breast cancer, even in the pamphlets that I pick up, there is more on breast cancer, they come with pictures of the breast, but they don't have those on the cervix, cervical cancer, or the Pap smear--those, they don't have.

Nevertheless, the community's level of awareness about breast cancer and mammography exams is limited. Organization representatives reported that even if a woman in the community knows that a mammography is a medical exam to detect breast cancer, she lacks knowledge about

screening guidelines, risk factors, diagnostic exams, treatment options after diagnosis, and prognosis.

Cervical Cancer and Pap smear Screenings.

All participants agreed that the majority of community women know about and adhere to cervical cancer screening guidelines. Organization representatives stated that a possible explanation for women's routine Pap smear screening may be due to many women having this exam performed conjunction with child care: "...Almost all women in LV have children, and when they go to the doctor, the doctor [tells them] to get checked for a Pap smear...even though sometimes they don't even know why but they get the exam done." (P1). This finding suggests the need for health care providers to improve their communication with community women about the purpose of this exam and its importance to detect cervical cancer. Additionally, it raises the question about whether childless women or those beyond reproductive age have access to information on Pap smear exams.

However, participants also reported that women in LV have significantly less knowledge about cervical cancer and Pap smear screenings than breast cancer and mammography. Specifically, they pointed to a lack of knowledge and misinformation about the risk factors for cervical cancer, especially those related to a woman's sexual behavior. They perceived that women's limited knowledge reflects adherence to traditional Mexican and Catholic beliefs that prohibit them from speaking about this type of cancer, as its risk factors involve a woman's sexual activity. For example, an organization representative shared: "I don't really hear much about cervical cancer. I don't know if it is because women are not aware of it or if it's included in their [routine check-up] but they have never mentioned anything to me" (P6). Yet, many women are aware that cervical cancer is associated with having multiple sex partners and

engaging in other “risky” sex practices, and given their own lack of risky behavior, they perceive they are not at risk to develop this type of cancer.

Dimension F: Resources Related to the Issue.

All participants agreed that LV has many local resources such as community organizations, collaborative partnerships, and volunteers. For example, community-based organizations and churches were often cited as invaluable resources that can and have been used to increase awareness on health issues, including breast and cervical cancer screening. The community’s willingness to support early detection efforts is evidenced by the fact that a few participants reported that their organizations were already supporting cancer screening on various levels. For example, community-based organizations reported integrating education efforts into their own programs even when the organizations’ focus was not solely health. Partnerships included collaborating on events, health fairs, or integrating a cancer screening component into existing programs and services.

Participants felt that health promotion staff in the community was quite knowledgeable about available resources, including the IBCCP. However, participants also expressed concern that the pool of available resources is shrinking in the midst of the state’s current economic situation:

P3: The only thing I have to say barrier-wise is so many partners... [are] broke... So many agencies and so many partners are struggling to continue to provide the services they need to provide. They’re not getting reimbursed, you know [what] I mean? It’s just, it’s tough out there...

Summary.

The different dimensions in the CRA lend support to the complexity of examining the various factors women face in obtaining breast and cervical cancer screening. Moreover, the findings of the CRA support the claim that place of residence or the community in which Mexican immigrant women reside is an important factor to take into account when examining mammography and Pap smear participation rates. In LV, current early detection efforts focus more on getting women screened rather than on increasing awareness about the importance and role of early detection. Despite the extent of cancer screening resources available, community representatives voiced a need for more education efforts, as not all of the women in the community are being reached. Another major concern was the economy and limited resources currently available to continue current work or expand early detection education or screening services.

CHAPTER 5

Discussion

The present study extends the current literature by: (a) demonstrating the importance of examining multi-level ecological factors to understand this population's mammography and Pap smear screening rates, (b) focusing on community factors that have not been well explored in Mexican immigrants' mammography and Pap smear utilization rates, and (c) supporting the importance of examining place as a way of contextualizing women's screening behaviors. Each of these points will be discussed in more detail next.

Importance of Adopting a Multi-level Ecological Approach

An ecological approach captures the complex and multifaceted factors influencing Mexican immigrant women's breast and cervical cancer screening behaviors. At the intrapersonal level, study findings revealed that community women have many misconceptions and inaccurate information about breast and cervical cancer and their respective screening exams. Interpersonal-level factors such as a woman's social network also play an important and nuanced role in her receipt of health information. In some cases, the social network facilitates the receipt of accurate information, and in some cases it promulgates misinformation. Fortunately, results indicate that at the institutional/ organization and cultural/community levels, LV has many facilitative factors in place to assist women in accessing screening resources, navigating the health care system, and receiving other types of support for screening. At the policy level, the socioeconomic and immigration status of women residing in LV plays a significant role in their ability to access screening information and services.

One major finding is that despite the high mammography and Pap smear screening rates reported by women living in LV, participants noted that women are misinformed about breast

and cervical cancer and their respective screening exams. For example, participants in Phase II reported that if women do not have a family history of breast cancer, they do not perceive being at risk of developing this type of cancer. Such responses are supported by quantitative data provided by community women in Phase I of the study. Similarly, many interviewees reported that women lack knowledge about cervical cancer, especially about the risk factors related to sexual activity. In particular, women had low perceived susceptibility because they were currently not engaged in sexual relations, or because they only had one partner. However, in arriving at this judgment, women were not taking into account their past sexual history or their partner's. These findings are consistent with the current literature indicating that Mexican immigrant women have little or no knowledge about these two types of cancer (Erwin, 2010). They are also concerning because if a woman does not know or is unable to understand the importance of early detection, she is less likely to obtain screenings (Valdez et al., 2001).

It is important to note that the lack of information was not seen as the women's fault by any of the participants. Rather, it was attributed to the lack of early detection information available in LV. This is contradictory to dominant health belief models often applied to research on Latina women's screening practices (Burke et al, 2009). Such models assume that a woman should know about the importance of early detection and obtain screenings, often without regard to women's differential access to screening information and services. Findings from the present study draw attention to the fact that even within one community, not all women have adequate access to information on the importance of early detection. Moreover, the availability of information and access to screening resources do facilitate Mexican immigrant women's adherence to mammography and screening guidelines.

Findings from the study also suggest that interpersonal factors play an important role in women's access to screening information and services. This finding is consistent with that of a previous study, where women noted receiving advice and encouragement to obtain mammograms from their female relatives and friends (Tejada et al., 2009). In LV, a woman's interactions with family, friends, and neighbors (i.e., her social network) were found to have a mixed influence on her perceptions about breast or cervical cancer. Participants reported that the exchange of health information among women in the community contributed to their holding myths and misconceptions about cancer and screening exams, but they also suggested that these networks are effective in informing women about screening resources available. Having information about screening resources available was especially useful for women not involved in community organizations or activities. The study's mixed results on the role of a woman's social networks on health behavior support a recent study's findings which suggest that social networks are not always positive or supportive (Viruell-Fuentes & Schulz, 2009). Consequently, Viruell-Fuentes and Schulz (2009) pointed to the need to examine social networks as "dynamic relationships influenced by the available resources within them and by the demands of the context in which they function."

Consistent with the literature on this subject, participants' socio-economic status played a prominent role in their ability to access screening resources in the community. Results for Phases I and II of the study indicate that financial barriers are a major concern for women in obtaining screening exams. It is not surprising that the cost of a screening exam is a primary concern, as 66% of residents in LV do not have health insurance (Shah & Whitman, 2005). Despite LV having many low-cost health facilities, the average cost of a doctor's visit at a local clinic is \$45 for an uninsured patient. This cost may seem reasonable and even low; however, for women who

are paid hourly, this may equal one day's salary. Thus, the cost of a screening exam is priced out of reach for many women. Finally, participants also reported that community women have concerns about paying for the treatment if a cancer is diagnosed. This is consistent with previous research showing that fears of cost of treatment may act as a barrier to Latina women's screening behaviors (Buki et al., 2004).

In addition, consistent with the literature, a woman's immigration status played an important role on women's breast and cervical cancer screening behaviors (Echeverria & Carrasquillo, 2006; Wallace et al., 2008). For immigrant women, factors such as limited access to screening information and services contribute to their lower mammography and Pap smear participation rates. However, LV's medical and community organizations continually work to increase awareness about screening resources available in the community. Moreover, participants report that such institutions and organizations are effective in delivering linguistic and culturally relevant information and resources.

Key Community Factors

The most significant finding from Phase I of this study was the high levels of mammography and Pap smear screening reported by participants despite their having socio-demographic characteristics that place them at risk of not screening. In the study, women in LV reported high mammography and Pap smear screening rates, 87% and 95% respectively. The mammography rates reported by the women in LV are higher than the national rate for all Latinas in general and women of Mexican descent (see Table 2). Data from 2005 indicate that only 59.2% Latinas and 56.2% women of Mexican descent report having had a mammogram within the past two years (ACS, 2009). The reported Pap smear screening rates among women in LV were also higher than the state and national average for all Latina women (see Table 2).

Nationally, in 2006 only 74.6% of all Latinas and 73.3% of women of Mexican descent reported having had a Pap smear exam within the past three years (ACS, 2009). That same year in the state of Illinois, 85.8% of Latina women reported having had a Pap smear exam within the past three years (Kaiser Family State Health, n.d.).

Previous studies have found screening rates among Latina immigrants to be high due to having been screened only once or to researchers not inquiring whether women were up to date with screenings. However, this was not the case for the women in the present sample; the women in LV were obtaining routine screenings. High Pap smear screening rates among Latina immigrants have also been attributed to the fact that this examination is generally a routine procedure for women of reproductive age (Abraido-Lanza et al., 2005; Shah & Whitman, 2005). This may be a contributing factor to the high rates reported by the women in the study; however, it does not account for the high mammography rates also reported by them.

Community Organizations and the Local Health Care System.

Perceived availability of health services in a Mexican immigrant community has also been found to influence women's breast and cervical cancer screening behaviors (Puschel et al., 2001). Study findings revealed that both organization and community representatives are attuned to the need for cancer screening education and services in LV. Several health facilities, community, and faith-based organizations work on reducing and eliminating place-based factors to increase women's access to information and screening services. Organizational and institutional practices reduce or eliminate known barriers to screening such as language access, transportation, and difficulty navigating the health care system. For example, participants indicated that community organizations play a crucial role in helping women navigate the health care system and become aware of screening resources available in the community.

The present study also highlights the information, referral, and advocacy services related to screening exams provided by health- and non-health-related organizations in the community. Previous studies have found that Latino immigrants are more likely to receive cancer screening information from non-health-related community sources more often than from health care providers and institutions (Gany et al., 2006). An effective strategy among community organizations is the provision of referrals to free mammography and Pap smear screening exams at local health facilities. For example, several of the organization representatives indicated that their educational workshops, events, or activities had a referral component, as the women would indicate that cost was a primary barrier to obtaining care.

Additionally, medical and community-based organizations effectively reduce language barriers to screening for women in the community. Despite the fact that more than half of the participants in Phase I spoke Spanish only, or spoke more Spanish than English, women did not report language as barrier to obtaining screening exams in the community. Possible explanations include the availability of bilingual health care professionals and interpreter services. Additionally, participants spoke at length about the community embracing its bilingual and bicultural identity. Community representatives' expectation that there should be bilingual providers in the community shows that the local health care system is taking into account the community's demographics and is tailoring services to be culturally and linguistically appropriate.

However, due to the limited resources and strained health systems found in LV, breast and cervical cancer efforts do not sufficiently meet the needs of all of the women in the community. Participants voiced a community-wide perception of insufficient women's health resources, including breast and cervical cancer screening education and services. Barriers at the

institutional and organization levels delay access to screening services and add bureaucratic hurdles that discourage Mexican immigrant women from receiving needed screening exams. Specifically, organization and community representatives reported that obtaining medical care in LV is a long and difficult process due to the limited capacity of the local healthcare system. Long waits to obtain exams can have serious implications for women who have cancer that is yet to be diagnosed. A later stage diagnosis compromises the quality of care and treatment options for a woman (ACS, 2009). The inability of community clinics in LV to meet the residents' screening needs of women reflects a wider problem about the availability of mammography screening services in Chicago. One investigation that assessed Chicago's health facilities' capacity to perform mammography exams uncovered that the city does not have the capacity to perform a mammography for all of the women who need exams (Shapiro et al., 2006).

In LV, many cancer detection programs are organized and delivered by a community-based organization or are carried out through partnerships among community, faith based, and medical organizations. Although these programs have been successful at reaching women in LV, findings suggest that they also are unlikely to reach women who are not active members in a community organization, are not established patients at a clinic, do not attend church, or are not religiously affiliated.

Findings also suggest that engaging in early detection education efforts primarily or solely through faith-based organizations may not be an optimal strategy. In LV, cancer outreach programs encountered some challenges in the type of cancer information that was allowed to be presented to women. Specifically, early detection workshops held in churches had been "toned down" with limited discussion on risk factors for cervical cancer. A recent study that inquired about Latina immigrants' opinion on whether churches are a good venue to provide health

information and services found differences based on where the women lived (Erwin et al., 2010). Women living in rural communities found church sites to be an optimal place to receive early detection information in comparison to women from urban communities felt that churches may be prohibitive on the type of information that would be provided (Erwin et al.). Thus, in urban communities, given the opportunity to do so, the types of organizations providing information about these cancers should be diversified.

LV's Sense of Community.

Participants' responses about community practices convey feelings of a *sense of community*. In particular, community and organization representatives emphasized the unique nature of social services provided in LV, residents' involvement to improve public services, and a strong sense of responsibility to serve the needs of the community expressed by medical and community organizations. To my knowledge, only one prior study has examined the implications of "sense of community" among Latina immigrants, and findings revealed that having a sense of community can enhance women's health promoting behaviors (Bathum & Baumann, 2007). Sense of community can be defined as "a feeling that members of a community have in relation to their belonging to a community, a feeling that members worry about each other and that the group is concerned about them, and a shared faith that the needs of the members will be satisfied through their commitment of being together" (McMillan & Chavis, 1986).

The sense of community and activism within LV allows for medical and community organizations to advocate for health care resources to address issues such as breast and cervical cancer screenings. For example, the story shared by an organization representative about the creation of a cancer outreach program as a result of community women's participation and activism points to sense of community shared among LV residents. Moreover, the women who

helped found the cancer outreach program continue to be involved and contribute by helping to provide transportation or donating small gifts to be used as incentives for women to attend education workshops. Community representatives also pointed to residents' strong involvement in other non-health related issues in the community, such immigration, which extends to women's access to medical care. Lastly, an organization representative commented on the uniqueness of LV among other communities in United States, illustrating this strong sense of community: "I think we are very fortunate to have all the services that we do and it comes from activism. These are communities that are built on activism" (P2).

Residents' Mexican identity and strong sense of community are a result of, and are nurtured by, LV's institutional and organizational history, practices, and Spanish language use. The affiliation between LV and Pilsen, a neighboring predominately Mexican-American community, was also mentioned by organization and community representatives as facilitating a sense of community. Due to their close geographical location, many of the community and medical organizations serve both LV and Pilsen; similarly, residents may access the programs and services at both locations. Organization representatives viewed both communities as comprising the Mexican community of Chicago. Despite their similarities, community representatives alluded to the distinct Mexican and immigrant characteristics of LV such as Spanish being the major language spoken in the streets, businesses, and organizations located within the community.

The Role of Place in Contextualizing Women's Screening Behaviors

Examining place can provide a more comprehensive picture of the factors influencing women's screening behaviors. One of the study's main contributions was the focus on place-based factors that facilitate mammography and Pap smear adherence among Mexican immigrant

women living in LV. For example, knowing the local community's readiness is critical to changing the current context and improving cancer screening participation.

Results show that LV is in the "Preparation" stage to address breast and cervical cancer screening in the community. Consistent with the "preparation" stage, LV offers modest support for efforts around the issue (Edwards et al., 2000). For example, participants recognize the existence of screening disparities among Mexican immigrant women and believe this issue should be addressed. In addition, several individuals and organizations are taking a leadership role on improving women's awareness of the importance of early detection as well as of screening services in the community. Despite the fact that current breast and cervical cancer screening resources are not sufficient for the size and needs of the population residing in LV, community efforts have been effective at reaching many segments of the population. Evidence points to this success owing to multiple strategies. Aside from breast and cervical cancer education outreach programs sponsored by health organizations, early detection efforts come from churches and women's advocacy groups.

Despite the numerous community-based and medical organizations working on breast and cervical cancer screening efforts in LV, participants reported no clear identifiable leaders working toward addressing this issue. A potential explanation for participants' perceived lack of leadership on this issue may be the fact that current efforts are not provided by organizations solely dedicated to this issue. That is, screening services and education programs have been taken up by the broader community health organizations as a component of their programs, events, and activities. However, the high mammography and Pap smear participation levels found in LV suggest the existence of some leadership that is making a difference on residents' screening rates. The next step for LV is to plan how current leadership and resources can be

leveraged to maximize the number of women who are exposed to early detection information and receive these medical exams.

Some of the implications for a community in the “Preparation” stage include developing additional strategies to expand current efforts to reach more women in the community. The community climate in LV indicates the existence of a strong foundation and community-wide support to extend current breast and cervical screening resources. LV can move forward in addressing breast and cervical cancer screening utilization rates through the following strategies: Leadership training, information dissemination, and community mobilization programs to expand current knowledge about breast and cervical cancer, the importance of early detection, and screening resources (Edwards et al., 2000; 2006). Interestingly, LV is already engaged in some of these strategies to some extent; however, there is a need for consistent efforts. Thus, current community collaborations can be built upon to allow for the expansion and maintenance of early detection education and screening services.

In conclusion, there is strong evidence that the high screening rates obtained in this study are due to the fact that LV’s community, faith-based, and medical organizations help women navigate an unfamiliar and complex health-care system. However, more funding is needed for LV to sustain and expand education and screening services that reach all women in the community. Although the IBCCP provides women with access to free screenings, the number of women who can take advantage of such programs is limited due to the existing capacity of the local health care system. Specifically, additional funding would increase the capacity of the local clinics to improve screening utilization by offering more screening appointments, increasing service hours, hiring additional personnel, and engaging in more outreach efforts. Outreach

efforts to increase women's awareness of screening information and services available would be particularly important, as it was the most commonly cited barrier to screening.

Implications for Future Research

A major implication from this study is the development of additional strategies and interventions aimed at targeting women who are still unaware of screening information and resources available. More research is also needed to explore women's perspectives on their sense of community and its influence on their cancer screening behaviors. Moreover, having identified place-based factors that influence screening behaviors in LV, it would be useful to explore whether these factors facilitate access to other preventative health care information and services as well. Finally, because the present study demonstrates the need for additional research on place-based factors, it would be important to extend this research to other Mexican immigrant communities and identify community resources and conditions that are amenable to intervention and change.

Study Limitations

As all studies do, this study has certain limitations. For Phase I, participants were recruited at local community centers and churches, which may have resulted in identifying women who were likely to obtain screenings due to their ties to a community organization (Katapodi et al., 2002). However, it is important to note that the high screening rates uncovered in this study are consistent with those reported in other studies examining screening participation among women in LV (Shah & Whitman, 2005; Whitman et al., 2007). Another potential limitation is that one local hospital and one community organization currently engaging in breast and cervical cancer outreach efforts did not participate in the study due to non-response.

However, several participants had knowledge of their efforts and were able to comment on their programs and services.

CHAPTER 6

Tables

TABLE 1.

Community Readiness Model, Score and Stage of Readiness

Stage	Description
1. No Awareness	Issue is not generally recognized by the community or leaders as a problem (or it may truly not be an issue).
2. Denial/ Resistance	At least some community members recognize that it is a concern, but there is little recognition that it might be occurring locally.
3. Vague Awareness	Most feel that there is a local concern, but there is no immediate motivation to do anything about it.
4. Preplanning	There is clear recognition that something must be done, and there may even be a group addressing it. However, efforts are not focused or detailed.
5. Preparation	Active leaders begin planning in earnest. Community offers modest support of efforts.
6. Initiation	Enough information is available to justify efforts. Activities are underway.
7. Stabilization	Activities are supported by administrators or community decision makers. Staff are trained and experienced.
8. Confirmation/ Expansion	Efforts are in place. Community members feel comfortable using services, and they support expansions. Local data are regularly obtained.
9. High Level of Community Ownership	Detailed and sophisticated knowledge exists about prevalence, causes, and consequences. Effective evaluation guides new directions. Model is applied to other issues.

TABLE 2.

Cancer Screening Rates Use (%) Among Women of Mexican Descent

	Little Village, Chicago in 2006	U.S* in 2005
Breast cancer screening, women 40 and older		
Mammography screening ever	87%	
Mammography exam within the past 2 years	11%	56.2%
Mammography exam within the past year	27%	38.5%
Cervical cancer screening, women 18 and older		
Pap smear screening ever	95%	
Pap smear screening within the past 3 years		73.3%
Pap smear screening within the past 2 years	92%	

*Note. Estimates are age adjusted to the 2000 Standard Population. Adapted from “National Health Interview Survey Public Use Data File 2005,” by National Center for Health Statistics, Centers for Disease Control and Prevention.

TABLE 3.

Little Village's Readiness Results

Calculated scores of each dimension, followed by the overall readiness score of Little Village

Dimension	Readiness Score	Stage of Readiness
A. Community Efforts	7.1	Stabilization
B. Community Knowledge of Efforts	4.4	Preplanning
C. Leadership	6.1	Initiation
D. Community Climate	5.3	Preparation
E. Community Knowledge of Issue	3	Vague Awareness
F. Resources	6	Initiation
Overall Stage of Readiness	5.4	Preparation

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APPENDIX A

Socio-demographic Health Questionnaire

English Version

1. What is your age? _____

2. How do you identify yourself? (Please check all that apply)

☐ White Latina ☐ Caribbean Latina

☐ Black Latina ☐ Native Latina

☐ Asian Latina ☐ Other: _____

3. Place of Birth (Country): _____

4. What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Cohabiting ☐ Widowed

5. Do you have children? ☐ Yes ☐ No If yes, how many? _____

6. Do you work outside home? ☐ Yes ☐ No If you answered yes:
How many days a week? _____ days a week
How many hours a day? _____ hours a day

7. How long have you lived in the United States? _____ years and _____ months ☐ all my life

8. What is the maximum level of formal education you have completed? (Please circle)

Grade school								High School				College				Post Graduate
1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	PG

9. What kind of health insurance do you have?

☐ Private

☐ Medicare, Medicaid

☐ None

☐ Other: _____

10. What was your family income during the past year? (Please fill in weekly, monthly, or annually)

_____ Weekly **or** _____ Monthly **or** _____ Annually

11- 15, Acculturation Items

For the following questions, please indicate your answer by checking the box.

16. Have you ever been diagnosed with cervical cancer? ☐ Yes ☐ No ☐ I do not know

17. Do you have a family history of cervical cancer? ☐ Yes ☐ No ☐ I do not know

If yes: which member of your family? (mark ALL that apply)

☐ Mother ☐ Sister ☐ Daughter
☐ Grandmother ☐ Aunt ☐ Other: _____

18. Have you ever been diagnosed with breast cancer? ☐ Yes ☐ No ☐ I do not know

19. Do you have a family history of breast cancer?

If yes: which member of your family? (mark ALL that apply)

☐ Mother ☐ Sister ☐ Daughter
☐ Maternal grandmother ☐ Maternal aunt ☐ Other: _____
☐ Paternal grandmother ☐ Paternal aunt

The following questions ask about your behaviors and beliefs regarding Pap smears. Please answer all the questions. Answer as truthfully as you can, based on what you really believe and/or do.

20. How often should a healthy woman your age have a Pap smear? Every... _____ Month(s) **or** _____ Year(s) **or** ☐ I do not know

21. Have you ever had a Pap smear? ☐ Yes ☐ No ☐ I do not remember

If you answered yes, please answer questions 22, 23, and 24. If you answered no, or you don't remember, please skip to question 25.

22. In the past five years, how many Pap smears have you had?

☐ One ☐ Two
☐ Three ☐ Four
☐ Five or more ☐ I do not remember

23. When did you have your most recent Pap smear? _____ Days ago _____ Weeks ago _____ Months ago _____ Years ago ☐ I do not remember

24. When you got your last Pap smear, was the female exam done because: (Mark ALL that apply)

- ☐ It was part of a routine checkup
☐ It was a requirement for getting my contraceptive prescription
☐ I had a gynecological problem
☐ It was part of my prenatal care
☐ I do not know ☐ Other reason: _____

If you have had a Pap smear before, skip to question 26.

25. If you have not had a Pap smear before, what were the reasons? (Mark ALL that apply)

- ☐ A doctor did not recommend it ☐ Pap smears are dangerous
☐ I don't need it at my age ☐ I am embarrassed to have that kind of exam
☐ I am worried about the cost ☐ I do not have time to get a Pap smear
☐ A Pap smear might be painful ☐ I do not need a Pap smear because I am healthy
☐ I have heard bad things about Pap smears ☐ I am afraid the Pap smear will cause cervical cancer
☐ I am afraid the Pap smear will show cancer ☐ I don't know
☐ Other reason: _____

For the following questions, please indicate how much you agree or disagree with each statement. Please circle a number between 1 and 9.

26. A healthy woman your age should get a Pap smear only when she has a gynecological problem → 1----- 2----- 3----- 4----- 5----- 6----- 7----- 8----- 9
 Completely Agree Somewhat Agree Neutral/ I don't know Somewhat Disagree Completely Disagree

27. A healthy woman your age should get a Pap smear only when she is pregnant → 1----- 2----- 3----- 4----- 5----- 6----- 7----- 8----- 9
 Completely Agree Somewhat Agree Neutral/ I don't know Somewhat Disagree Completely Disagree

28. A healthy woman your age should get a Pap smear only when a doctor or nurse recommends one → 1----- 2----- 3----- 4----- 5----- 6----- 7----- 8----- 9
 Completely Agree Somewhat Agree Neutral/ I don't know Somewhat Disagree Completely Disagree

29. A woman who is past menopause does not need to get a Pap smear → 1----- 2----- 3----- 4----- 5----- 6----- 7----- 8----- 9
 She definitely does not need to get one She probably does not need to get one Neutral/ I don't know She probably needs to get one She definitely needs to get one

30. Pap smears are painful → 1----- 2----- 3----- 4----- 5----- 6----- 7----- 8----- 9
 Completely Agree Somewhat Agree Neutral/ I don't know Somewhat Disagree Completely Disagree

31. Pap smears are too expensive → 1----- 2----- 3----- 4----- 5----- 6----- 7----- 8----- 9
 Completely Agree Somewhat Agree Neutral/ I don't know Somewhat Disagree Completel
 y Disagree

32. It is possible to have cervical cancer without symptoms → 1----- 2----- 3----- 4----- 5----- 6----- 7----- 8----- 9
 Completely Agree Somewhat Agree Neutral/ I don't know Somewhat Disagree Completely Disagree

33. If I were diagnosed with cervical cancer, I would die from it → 1----- 2----- 3----- 4----- 5----- 6----- 7----- 8----- 9
 Completely Agree Somewhat Agree Neutral/ I don't know Somewhat Disagree Completely Disagree

34. How likely are you to get cervical cancer? → 1----- 2----- 3----- 4----- 5----- 6----- 7----- 8----- 9
 Very likely Somewhat Likely Neutral/ I don't know Somewhat not likely Not at all Likely

35. Do you know of any traditional ways to prevent cervical cancer? ☐ Yes ☐ No

If you know traditional ways to prevent cervical cancer, could you mention some of them?

36. Have any of the following people ever encouraged you to have a Pap smear? (Mark ALL that apply)

- | | |
|--------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Your husband or partner | <input type="checkbox"/> A doctor |
| <input type="checkbox"/> Your child or children | <input type="checkbox"/> A nurse |
| <input type="checkbox"/> Other family members | <input type="checkbox"/> Another health professional |
| <input type="checkbox"/> A friend | <input type="checkbox"/> No one |
| <input type="checkbox"/> Someone else: _____ | |

37. Do you know where to go when you need to get a Pap smear?

☐ Yes ☐ No

38. Do you have any special preference for the gender of the health professional who is going to perform the Pap smear procedure?

- ☐ Female ☐ Male
- ☐ No preference

39. Has a doctor or nurse ever done a clinical breast exam for you?

(A clinical breast exam is when the doctor or nurse tries to feel any lumps in your breast)

☐ Yes ☐ No ☐ I do not know

If you answered yes, please answer questions 40 and 41. If you answered no or you don't know, please skip to question 42.

40. About how long ago did you have your last clinical breast exam?

_____ Days ago

_____ Weeks ago

_____ Months ago

_____ Years ago

☐ I do not remember

41. What was the reason for your last clinical breast exam by a doctor or nurse?

- ☐ It was part my regular check-up
- ☐ Because I had a problem in my breast
- ☐ I do not know ☐ Other reason: _____

42. Do you have any special preference for the gender of the health professional who is going to perform the clinical breast exam?

☐ Female

☐ Male

☐ No preference

43. Have you ever been shown how to do your own breast self-exam?

☐ Yes ☐ No ☐ I do not remember

44. Have you ever examined your breasts?

☐ Yes ☐ No

45. How often should a healthy woman your age do a breast self-exam? Every...

_____ Month(s) **or** _____ Year(s) **or** ☐ I do not know

46. How often should a healthy woman your age have a mammogram? Every...

☐ A person my age does not require a mammogram

Month(s) **or** Year(s) **Or** ☐ I do not know

For the following questions, please indicate how much you agree or disagree with each statement.

Answer as truthfully as you can, based on what you really believe and/or do. Please circle a number between 1 and 9.

47. I know how to do the breast self-exam

→ 1-----2-----3-----4-----5-----6-----7-----8-----9
Completely Somewhat Neutral/ Somewhat Completely
Agree Agree I don't know Disagree Disagree

48. I feel uncomfortable or embarrassed examining my own breasts

→ 1-----2-----3-----4-----5-----6-----7-----8-----9
Completely Somewhat Neutral/ Somewhat Completely
Agree Agree I don't know Disagree Disagree

49. If I were diagnosed with breast cancer, I would die from it

→ 1-----2-----3-----4-----5-----6-----7-----8-----9
Completely Somewhat Neutral/ Somewhat Completely
Agree Agree I don't know Disagree Disagree

50. Young women are at higher risk of getting breast cancer than older women

→ 1-----2-----3-----4-----5-----6-----7-----8-----9
Completely Somewhat Neutral/ Somewhat Completely
Agree Agree I don't know Disagree Disagree

51. It is difficult to get a mammogram → 1----- 2----- 3----- 4----- 5----- 6----- 7----- 8-----9
 Completely Agree Somewhat Agree Neutral/ I don't know Somewhat Disagree Completely Disagree

52. A healthy woman could suffer from breast cancer after being hit in her breast → 1----- 2----- 3----- 4----- 5----- 6----- 7----- 8-----9
 Completely Agree Somewhat Agree Neutral/ I don't know Somewhat Disagree Completely Disagree

53. How likely are you to get breast cancer? → 1----- 2----- 3----- 4----- 5----- 6----- 7----- 8-----9
 Very Likely Somewhat Likely Neutral/ I don't know Not very Likely Not Likely at all

54. Have you ever had a mammogram? ☐ Yes ☐ No ☐ I do not remember

If you answered yes, please answer questions 55,56 and 57. If you answered no or you don't remember, please skip to question 58.

55. How many mammograms have you had in the last five years? ☐ One ☐ Two
☐ Three ☐ Four
☐ Five or more ☐ I do not remember

56. About how long ago did you have your last mammogram? ☐ I do not remember
 _____ Days ago _____ Weeks ago _____ Months ago _____ Years ago

57. Why did you have your last mammogram? ☐ I asked my doctor for a mammogram
☐ The doctor/nurse recommended the mammogram
☐ I do not remember ☐ Other reason: _____

58. If you have not had a mammogram before, what were the reasons? (Mark ALL that apply)

- | | |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> A doctor did not recommend it | <input type="checkbox"/> Mammogram X-Rays are dangerous |
| <input type="checkbox"/> I don't need it at my age | <input type="checkbox"/> I am embarrassed to have that kind of exam |
| <input type="checkbox"/> I am worried about the cost | <input type="checkbox"/> I do not have time to get a mammogram |
| <input type="checkbox"/> A mammogram might be painful | <input type="checkbox"/> I do not need a mammogram because I am healthy |
| <input type="checkbox"/> I have heard bad things about mammograms | <input type="checkbox"/> I am afraid the mammogram will cause breast cancer |
| <input type="checkbox"/> I am afraid the mammogram will show cancer | <input type="checkbox"/> I don't know |
| | <input type="checkbox"/> Other reason: _____ |

59. Have any of the following people ever encouraged you to have a mammogram? (Mark ALL that apply)

☐ Your husband or partner

☐ Your child or children

☐ Other family members

☐ A friend

☐ Someone else: _____

☐ A doctor

☐ A nurse

☐ Another health professional

☐ No one

60. Through what kind of mass media do you usually get information about women's health care? (Mark ALL that apply)

☐ Radio

☐ T.V.

☐ Magazines

☐ Newspapers

☐ Videos

☐ Community health programs

☐ None

☐ Other: _____

61. In what language do you prefer to get information about women's health care?

☐ Spanish

☐ English

☐ No preference

62. When you need to make an appointment to see a doctor, do you encounter any of the following barriers: (Mark ALL that apply)

☐ I do not have transportation

☐ I would need to wait too long to get the appointment

☐ I do not have child care

☐ I have language barriers when talking to the nurses or doctors

☐ I feel doctors or nurses treat me differently because I am Latina

☐ I cannot afford to pay for health care

Thank you for completing this survey.

Spanish Version

1. Edad: _____

2. ¿Cómo se describiría usted misma? (marque todas las que se apliquen)

- ☐ Latina Blanca
 ☐ Latina Indígena
☐ Latina Africana/Caribeña
 ☐ Latina Mestiza
☐ Latina Oriental/Asiática
 ☐ Otro: _____

3. Lugar de nacimiento (País): _____

4. ¿Cuál es su estado civil? ☐ Soltera ☐ Casada ☐ Divorciada ☐ Unión libre ☐ Viuda

5. ¿Tiene niños? ☐ Sí ☐ No Si su respuesta es positiva, cuantos niños tiene? _____

6. ¿Trabaja usted afuera de su casa? ☐ Sí ☐ No Si su respuesta es positiva responda las siguientes preguntas:
 ¿Cuántos días a la semana? _____ días a la semana
 ¿Cuántas horas al día? _____

7. ¿Por cuánto tiempo ha vivido en los Estados Unidos? _____ Años y _____ Meses ☐ Mi vida entera

8. ¿Cuál es el máximo nivel de educación formal que usted ha alcanzado? Por favor señale con un círculo su respuesta.

Escuela primaria								Escuela secundaria				Universidad				Post- grado
1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	PG

9. ¿Qué clase de seguro de salud tiene actualmente? ☐ Privado ☐ Medicare, Medicaid ☐ Ninguno ☐ Otro: _____

10. ¿Cuál fue su sueldo o ingreso familiar durante el último año? (Por favor escriba su ingreso semanal, mensual o anual)

_____ Semanal o _____ Mensual o _____ Anual

11 - 15, Acculturation Items

Para las siguientes preguntas, por favor indique su respuesta marcando el cuadro correspondiente.

16. ¿Ha sufrido alguna vez de cáncer de la cerviz? ☐ Sí ☐ No ☐ No sé

17. ¿Ha tenido previa historia familiar de cáncer de la cerviz? ☐ Sí ☐ No ☐ No sé

Si su respuesta fue positiva, ¿cuál miembro de su familia ha sufrido de cáncer de la cerviz?
(marque todas las opciones que se apliquen)

☐ Mamá ☐ Hermana ☐ Hija
☐ Abuela ☐ Tía ☐ Otro: _____

18. ¿Ha sufrido alguna vez de cáncer de seno? ☐ Sí ☐ No ☐ No sé

19. ¿Ha tenido previa historia familiar de cáncer de seno? ☐ Sí ☐ No ☐ No sé

Si su respuesta fue positiva, ¿cuál miembro de su familia ha sufrido de cáncer de seno?
(marque todas las opciones que se apliquen)

☐ Mamá ☐ Hermana ☐ Hija
☐ Abuela materna ☐ Tía materna ☐ Otro: _____
☐ Abuela paterna ☐ Tía paterna

Las siguientes preguntas están relacionadas con sus comportamientos y creencias acerca del Papanicolau. Por favor responda todas las preguntas de la manera más sincera posible.

20. ¿Con qué frecuencia una mujer sana de su edad debe hacerse el Papanicolau? Cada... _____ Mes(es) ☐ o _____ Año(s) ☐ ☐ No sé

21. ¿Se ha hecho usted alguna vez en su vida un Papanicolau? ☐ Sí ☐ No ☐ No recuerdo

Si su respuesta fue positiva, por favor responda las preguntas 22, 23, y 24. Si su respuesta fue negativa, o no recuerda, salte directamente a la pregunta 25.

22. En los últimos 5 años, ¿cuántas veces se ha hecho el examen del Papanicolau? ☐ Uno ☐ Dos
☐ Tres ☐ Cuatro
☐ Cinco o más ☐ No recuerdo

23. ¿Cuándo obtuvo su más reciente Papanicolau? _____ Días _____ Semanas _____ Meses _____ Años ☐ No recuerdo

24. Cuándo usted se hizo su último Papanicolau, ¿cuáles fueron las razones principales para hacerse este examen? (Marque TODAS las opciones que se apliquen)

- ☐ Como parte de mis chequeos regulares de salud
- ☐ Como requerimiento para obtener la prescripción de mis pastillas anticonceptivas
- ☐ Tenía un problema ginecológico
- ☐ Como parte de mis controles prenatales
- ☐ No sé ☐ Otra razón: _____

Si se ha hecho el Papanicolau anteriormente, salte a la pregunta 26.

25. En caso de no haberse hecho un Papanicolau anteriormente, ¿cuáles fueron las principales razones para no haberse hecho este examen? (marque TODAS las opciones que se apliquen)

- | | |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| <input type="checkbox"/> El doctor no me lo recomendó | <input type="checkbox"/> No tuve tiempo para hacerme este examen |
| <input type="checkbox"/> A mi edad no necesito hacerme este examen | <input type="checkbox"/> No lo necesito por que estoy sana |
| <input type="checkbox"/> Estaba preocupada acerca del costo de este examen | <input type="checkbox"/> He escuchado malos comentarios acerca de este examen |
| <input type="checkbox"/> Pensaba que este examen podría ser doloroso e incomodo | <input type="checkbox"/> Me da miedo que este examen muestre que tengo cáncer |
| <input type="checkbox"/> Pensaba que este examen podría ser peligroso | <input type="checkbox"/> Me da miedo que este examen me cause cáncer de la cerviz |
| <input type="checkbox"/> Me daba vergüenza que me hagan este examen | <input type="checkbox"/> No sé |
| | <input type="checkbox"/> Otra razón: _____ |

En las siguientes preguntas por favor indique si usted está de acuerdo o no con cada uno de los enunciados. Por favor marque con un círculo el número del 1 al 9 que indique su respuesta.

26. Una mujer sana debe hacerse el Papanicolau solo cuando tiene un problema ginecológico	→	1-----	2-----	3-----	4-----	5-----	6-----	7-----	8-----	9
		Definitivamente		Probablemente		No estoy segura/ No sé		Probablemente		Definitivamente
		Sí		Sí				No		No

27. Una mujer sana debe hacerse el Papanicolau solo cuando está embarazada	→	1-----	2-----	3-----	4-----	5-----	6-----	7-----	8-----	9
		Definitivamente		Probablemente		No estoy segura/ No sé		Probablemente		Definitivamente
		Sí		Sí				No		No

28. Una mujer sana debe hacerse el Papanicolau solo cuando el doctor o enfermera lo recomienda	→	1-----2-----3-----4-----5-----6-----7-----8-----9 Definitivamente Sí Probablemente Sí No estoy segura/ No sé Probablemente No Definitivamente No
29. Una mujer que ha pasado por la menopausia no necesita hacerse el Papanicolau	→	1-----2-----3-----4-----5-----6-----7-----8-----9 Definitivamente no necesita hacérselo Probablemente no necesita hacérselo No estoy segura/ No sé Probablemente sí necesita hacérselo Definitivamente sí necesita hacérselo
30. El examen del Papanicolau es doloroso	→	1-----2-----3-----4-----5-----6-----7-----8-----9 Definitivamente Sí Probablemente Sí No estoy segura/ No sé Probablemente No Definitivamente No
31. El examen del Papanicolau es costoso	→	1-----2-----3-----4-----5-----6-----7-----8-----9 Definitivamente no es costoso Probablemente no es costoso No estoy segura/ No sé Probablemente sí es un poco costoso Definitivamente sí es muy costoso
32. Es posible sufrir de cáncer de la cerviz y no tener síntomas	→	1-----2-----3-----4-----5-----6-----7-----8-----9 Definitivamente Sí Probablemente Sí No estoy segura/ No sé Probablemente No Definitivamente No
33. Si me diagnostican que tengo cáncer de la cerviz, quiere decir que moriré de eso	→	1-----2-----3-----4-----5-----6-----7-----8-----9 Definitivamente Sí Probablemente Sí No estoy segura/ No sé Probablemente No Definitivamente No
34. ¿Qué tanto cree usted estar en riesgo de sufrir de cáncer de la cerviz?	→	1-----2-----3-----4-----5-----6-----7-----8-----9 Alto riesgo Riesgo moderado No estoy segura/ No sé Poco riesgo Ningún Riesgo

35. Según sus creencias culturales, ¿tiene usted conocimiento de algún método tradicional que prevenga el cáncer de la cerviz? ☐ Sí ☐ No

Si su respuesta anterior fue positiva, ¿podría mencionar algunos de estos métodos tradicionales?

36. ¿Alguna de estas personas la han animado a que se haga el examen de la cerviz? (marque TODAS las que se apliquen)

<input type="checkbox"/> Esposo o compañero	<input type="checkbox"/> El doctor
<input type="checkbox"/> Hijos / hijas	<input type="checkbox"/> La enfermera
<input type="checkbox"/> Otro miembro de la familia	<input type="checkbox"/> Otro profesional de la salud
<input type="checkbox"/> Una amiga	<input type="checkbox"/> Nadie
<input type="checkbox"/> Alguna otra persona: _____	

37. ¿Sabe usted a donde ir cuando necesita hacerse el examen del Papanicolau? ☐ Sí ☐ No

38. ¿Tiene usted una preferencia especial con respecto al sexo de la persona que debe hacerle el Papanicolau?

<input type="checkbox"/> Mujer	<input type="checkbox"/> Hombre
<input type="checkbox"/> Me es indiferente	

Las siguientes preguntas están relacionadas con sus comportamientos e ideas acerca del auto examen de seno, examen clínico del seno, y la mamografía. Por favor responda todas las preguntas de la manera más sincera posible.

39. ¿Alguna vez una enfermera o doctor le ha hecho un examen clínico de los senos? (El examen clínico de los senos es cuando el doctor o la enfermera examinan sus senos para detectar cualquier tipo de masa o abultamiento anormal de los senos)

☐ Sí ☐ No ☐ No sé

Si su respuesta fue positiva, por favor responda las preguntas 40 y 41. Si su respuesta fue negativa, o no recuerda, salte directamente a la pregunta 42.

40. ¿Hace cuánto tiempo usted obtuvo su último examen clínico de los senos?

_____ Días _____ Semanas _____ Meses _____ Años ☐ No recuerdo

41. ¿Cuál fue la razón por la cual le hicieron su último examen clínico de los senos?

- ☐ Como parte de mis chequeos médicos regulares
☐ Porque tenía un problema de los senos
☐ No sé ☐ Otra razón: _____

42. ¿Tiene usted una preferencia especial con respecto al sexo de la persona que debe hacerle el examen clínico de los senos?

☐ Mujer ☐ Hombre ☐ Me es indiferente

43. ¿Alguna vez le han enseñado a hacerse el auto examen de los senos?

☐ Sí ☐ No ☐ No recuerdo

44. ¿Alguna vez se ha examinado los senos usted misma? ☐ Sí ☐ No

45. ¿Con qué frecuencia una mujer sana de su edad debe hacerse el auto examen de los senos? Cada...

_____ Mes(es) ☐ _____ Año(s) ☐ ☐ No sé

46. ¿Con qué frecuencia una mujer sana de su edad debe hacerse una mamografía? Cada...

☐ Una persona de mi edad no debe hacérsela
_____ Mes(es) ☐ _____ Año(s) ☐ ☐ No sé

En las siguientes preguntas por favor indique si usted está de acuerdo o no con cada uno de los enunciados. Por favor responda todas las preguntas de la manera más sincera posible y marque con un círculo el número del 1 al 9 que indique su respuesta.

47. Yo sé como se debe hacer el auto examen de los senos.

→ 1----- 2----- 3----- 4----- 5----- 6----- 7----- 8----- 9
Definitivamente Sí Probablemente Sí No estoy segura/ No sé Probablemente No Definitivamente No

48. Yo me siento avergonzada e incómoda de examinarme mis senos	→	1----- 2----- 3----- 4----- 5----- 6----- 7----- 8----- 9 Definitivamente Sí Probablemente Sí No estoy segura/ No sé Probablemente No Definitivamente No
49. Si me diagnostican que tengo cáncer de seno, quiere decir que moriré de eso	→	1----- 2----- 3----- 4----- 5----- 6----- 7----- 8----- 9 Definitivamente Sí Probablemente Sí No estoy segura/ No sé Probablemente No Definitivamente No
50. Las mujeres jóvenes tienen mas riesgo de sufrir cáncer de seno que las mujeres mayores	→	1----- 2----- 3----- 4----- 5----- 6----- 7----- 8----- 9 Definitivamente Sí Probablemente Sí No estoy segura/ No sé Probablemente No Definitivamente No
51. ¿Usted piensa que es difícil obtener una mamografía?	→	1----- 2----- 3----- 4----- 5----- 6----- 7----- 8----- 9 Definitivamente Sí Probablemente Sí No estoy segura/ No sé Probablemente No Definitivamente No
52. Una mujer sana podría desarrollar cáncer de seno a raíz de haber sufrido un golpe en los senos	→	1----- 2----- 3----- 4----- 5----- 6----- 7----- 8----- 9 Definitivamente Sí Probablemente Sí No estoy segura/ No sé Probablemente No Definitivamente No
53. ¿Qué tanto cree usted estar en riesgo de sufrir de cáncer de seno?	→	1----- 2----- 3----- 4----- 5----- 6----- 7----- 8----- 9 Alto riesgo Riesgo moderado No estoy segura/ No sé Poco riesgo Ningún Riesgo
54. ¿Se ha hecho alguna vez una mamografía? <div style="display: flex; justify-content: flex-end; gap: 20px; margin-top: 10px;"> <input type="checkbox"/> Sí <input type="checkbox"/> No <input type="checkbox"/> No recuerdo </div>		

Si su respuesta anterior fue positiva, responda las preguntas 55, 56 y 57. Si su respuesta fue negativa, o no recuerda, salte directamente a la pregunta 58.

55. ¿Cuántas mamografías se ha hecho durante los últimos cinco años?

☐ Uno

☐ Dos

☐ Tres

☐ Cuatro

☐ Cinco o más

☐ No recuerdo

56. ¿Hace cuanto tiempo le hicieron su última mamografía?

____ Días ____ Semanas ____ Meses ____ Años

☐ No recuerdo

57. ¿Le solicitó usted la última mamografía a su enfermera o doctor, o fue su doctor o enfermera quien le solicitó su última mamografía?

☐ Yo le solicité a mi doctor una mamografía

☐ El doctor o enfermera fue quien me recomendó la mamografía

☐ No recuerdo

☐ Otra razón: _____

58. En caso de no haberse hecho una mamografía anteriormente, ¿cuáles fueron las principales razones para no hacerse este examen? (marque TODAS las que se apliquen)

☐ El doctor no me lo recomendó

☐ Pensaba que este examen podría ser peligroso

☐ A mi edad no se necesita hacer este examen

☐ He escuchado malos comentarios acerca de este examen

☐ Estaba preocupada acerca del costo de este examen

☐ No tengo tiempo para hacerme este examen

☐ Pensaba que este examen podría ser doloroso e incómodo

☐ No lo necesito por que estoy sana

☐ Me daba vergüenza que me hagan este examen

☐ Me da miedo que este examen me cause cáncer de seno

☐ Me da miedo que este examen muestre que tengo cáncer

☐ No sé

☐ Otra razón: _____

59. ¿Alguna de estas personas la han animado a que se haga el examen de mamografía? (marque TODAS las que se apliquen)

☐ Esposo o compañero

☐ El doctor

☐ Hijos / hijas

☐ La enfermera

☐ Otro miembro de la familia

☐ Otro profesional de la salud

☐ Una amiga

☐ Nadie

☐ alguna otra persona: _____

60. ¿A través de cuáles medios de comunicación usted está acostumbrada a recibir información acerca de la salud de la mujer? (Marque TODAS las que apliquen)

- ☐ Radio
- ☐ T.V.
- ☐ Revistas
- ☐ Periódicos

- ☐ Videos
- ☐ Programas de salud comunitarios
- ☐ Ninguno
- ☐ Otro: _____

61. Prefiere recibir la información en:

- ☐ Español
- ☐ Inglés
- ☐ Me es indiferente

62. Cuando usted necesita hacer una cita con su doctor, ¿cuáles son las principales dificultades que se le presentan? (marque TODAS las que se apliquen)

- ☐ No tengo transporte
- ☐ Debo esperar mucho tiempo para que me den la cita
- ☐ No tengo quien me cuide mis hijos
- ☐ Tengo barreras del lenguaje que me impide comunicarme con las enfermeras o doctores
- ☐ Siento que los doctores me tratan de una manera diferente por que soy latina
- ☐ No puedo pagar por los servicios de salud

Le agradecemos por haber completado esta encuesta.

APPENDIX B

Recruitment Scripts

Phase I

Recruitment Script: English Version

Project about the Participation of Latina Women in Medical Services

Recruitment script for community gatekeepers:

Yadira Montoya, an undergraduate student at the University of Illinois at Urbana-Champaign, is working in a summer research project about the participation of Latina women of Chicago in healthcare screenings and their access to medical services.

Yadira is seeking Latina women ages 18-64 to participate in a questionnaire that asks questions about health screenings and access to health care. The purpose of the study is to examine the knowledge, beliefs, and experiences of Latinas in obtaining breast and cervical cancer screenings.

The study will be anonymous and information collected will be kept confidential. If you are interested please sign your name and number in the following sheet. If you have any questions please contact Yadira Montoya at ymontoya@uiuc.edu or by calling (217)260-7861.

Recruitment Script: Spanish Version

Proyecto Sobre la Participación de la Mujer Latina en Servicios Médicos

Hoja de reclutamiento para líderes de la comunidad:

Yadira Montoya, estudiante de la Universidad de Illinois en Urbana-Champaign, está trabajando este verano en un proyecto sobre la participación de la mujer Latina en Chicago en exámenes de salud y su acceso a servicios médicos.

Yadira está buscando a mujeres Latinas que tengan entre 18-64 años de edad para que participen en este proyecto. Si deciden participar, llenarán una encuesta, que contiene preguntas sobre su participación en los exámenes de salud y su acceso a servicios médicos. El propósito de este proyecto es examinar el conocimiento, creencias, y experiencias que las mujeres Latinas tienen al obtener exámenes de la cerviz y mamografías.

La información colectada será anónima y confidencial. Si Ud. esta interesada en éste proyecto o tiene alguna pregunta puede contactar a Yadira Montoya al (217)260-7861 o ymontoya@uiuc.edu.

Phase II

Recruitment Script for Organization Representatives: English Version

TITLE OF PROJECT: Community influences on cancer screening behaviors among Mexican immigrants.

RECRUITMENT SCRIPT:

Dear _____,

My name is Yadira Montoya and currently working on my graduate degree at the University of Illinois at Urbana-Champaign. I am a long time resident of Little Village and I am very interested in connecting my research to women's health issues in the community. I am currently working on my Master's research project with Dr. Lydia P. Buki on issues of access to medical services among Latina immigrants.

I am writing to you because I would like to invite you to participate in my project. In the study, I will examine the community factors that influence the participation of Mexican immigrant women in health programs. I am interested in learning more about the information, resources, and services related to women's health available to immigrant women living in the community. I will be talking with key community leaders to learn more about the factors that impede or enable women to access cancer screening services. One meeting will take place and it should last approximately 60-90 minutes.

Please let me know whether you are interested in participating or have any questions about this study. You can contact me by telephone at (217)260-7861 or by email ymontoya@illinois.edu.

Your knowledge about the community would be an important contribution to this project. Thank you very much for your time and consideration.

Sincerely,
Yadira Montoya

Recruitment Script for Community Representatives: English Version

TITLE OF PROJECT: Community influences on cancer screening behaviors among Mexican immigrant women.

RECRUITMENT SCRIPT FOR COMMUNITY WOMEN:

Dear _____,

My name is Yadira Montoya and currently working on my graduate degree at the University of Illinois at Urbana-Champaign. I am a long time resident of Little Village and I am very interested in connecting my research to women's health issues in the community. I am currently working on my Master's research project with Dr. Lydia P. Buki on issues of access to medical services among Latina immigrants.

I am writing to you because I would like to invite you to participate in my project. In the study, I will examine the community factors that influence the participation of Mexican immigrant women in health programs. I am interested in learning more about the information, resources, and services related to women's health available to immigrant women living in the community. I will be talking with women living the community to learn more about the factors that impede or enable facilitate access to cancer screening services. One meeting will take place and it should last approximately 60-90 minutes.

Please let me know whether you are interested in participating or have any questions about this study. You can contact me by telephone at (217)260-7861 or by email ymontoya@illinois.edu.

Your knowledge about the community would be an important contribution to this project. Thank you very much for your time and consideration.

Sincerely,
Yadira Montoya

Recruitment Script for Organization Representatives: Spanish Version

TÍTULO DEL PROYECTO: Influencias comunitarias en las tasas de los exámenes de detección en mujeres inmigrantes Mexicanas.

GUION DE RECLUTAMIENTO:

Estimado/a _____,

Mi nombre es Yadira Montoya y soy una estudiante de post grado en la Universidad de Illinois en Urbana-Champaign. He vivido en La Villita desde niña, y estoy muy interesada en enfocar mis estudios a temas de salud de la mujer en la comunidad. Actualmente estoy trabajando en un proyecto para mi tesis con la Dra. Lydia P. Buki sobre el acceso que mujeres Latinas inmigrantes tienen a servicios médicos.

Le estoy escribiendo porque me gustaría invitarlo/a a participar en mi proyecto. En el proyecto, examinaré los factores comunitarios que afectan la participación de mujeres inmigrantes Mexicanas en programas de salud. Estoy interesada en el tipo de información, recursos, y exámenes de detección disponibles para mujeres que viven en la comunidad.

Estaré hablando con líderes de la comunidad con el fin de obtener sus perspectivas sobre factores que impiden o facilitan que mujeres tengan acceso a exámenes del cáncer. Si acepta participar en este proyecto, nos vamos a reunir una sola vez y la junta durará aproximadamente 60-90 minutos.

Favor de avisarme si usted está interesado/a en participar. Si tiene alguna pregunta acerca de este proyecto, me puede contactar por teléfono al (217) 260-7861 o por correo electrónico al ymontoya@illinois.edu.

Su conocimiento sobre la comunidad contribuiría mucho para este proyecto.
Le agradezco mucho por su tiempo y amable consideración.

Sinceramente,
Yadira Montoya

Recruitment Script for Community Representatives: Spanish Version

TÍTULO DEL PROYECTO: Influencias comunitarias para recibir los exámenes de detección en mujeres inmigrantes Mexicanas.

GUION DE RECLUTAMIENTO PARA MUJERES DE LA COMUNIDAD:

Estimado/a _____,

Mi nombre es Yadira Montoya y soy una estudiante de post grado en la Universidad de Illinois en Urbana-Champaign. He vivido en La Villita desde niña, y estoy muy interesada en enfocar mis estudios a temas de salud de la mujer en la comunidad. Actualmente estoy trabajando en un proyecto para mi tesis con la Dra. Lydia P. Buki sobre el acceso que mujeres Latinas inmigrantes tienen a servicios médicos.

Le estoy escribiendo porque me gustaría invitarlo/a a participar en mi proyecto. En el proyecto, examinaré los factores comunitarios que afectan la participación de mujeres inmigrantes Mexicanas en programas de salud. Estoy interesada en el tipo de información, recursos, y exámenes de detección disponibles para mujeres que viven en la comunidad.

Yo estaré hablando con mujeres que viven en la comunidad para aprender más sobre los factores que impiden o facilitan el acceso a los exámenes de detección de cáncer. Nos vamos a reunir una vez y la junta durará aproximadamente 60-90 minutos.

Favor de avisarme si usted está interesado/a en participar. Si tiene alguna pregunta acerca de este proyecto, me puede contactar por teléfono al (217) 260-7861 o por correo electrónico al ymontoya@illinois.edu.

Su conocimiento sobre la comunidad contribuiría mucho para este proyecto. Le agradezco mucho por su tiempo y amable consideración.

Sinceramente,
Yadira Montoya

APPENDIX C

Community Readiness Assessment

English Version

Community Influences on Cancer Screening Behaviors among Mexican Immigrant Women

This Community Readiness Assessment (CRA) has been adapted from the original version by Tri-Ethnic Center for Prevention Research at Colorado State University.

QUESTIONS ABOUT YOURSELF

1. What is your age? _____
2. What is your ethnicity? _____
3. What is your position? _____
4. How long have you been in this position? _____
5. What is the main demographic of the population you serve?
 - a. Mexican immigrants: _____
 - b. Puerto Rican: _____
 - c. Other: _____
6. How long have you been involved with the Latino community?
7. How long have you been involved in the Little Village community?

For the following questions in the interview, the word community will refer to Little Village and the population I am interested in are Mexican immigrant women.

COMMUNITY EFFORTS AND KNOWLEDGE ABOUT EARLY DETECTION

1. Please identify the programs and services available in Little Village aimed at increasing awareness about the importance of early detection for breast cancer (BC) and providing BC screening services?
 - a. Who do these programs serve?
 - b. Who is responsible for offering these services?
 - c. How long have these efforts been going on in the community?
 - d. Is there a need to expand these efforts/services?
 - e. What are the strengths of existing efforts?
 - f. What are the weaknesses of existing efforts?

2. Please identify the programs and services in the community aimed at increasing awareness about the importance of early detection for cervical cancer (CC) and CC screening services?
 - a. Who do these programs and services serve?
 - b. Who is responsible for offering these services?
 - c. How long have these efforts been going on in the community?
 - d. Is there a need to expand these efforts/services?
 - e. What are the strengths of existing efforts?
 - f. What are the weaknesses of existing efforts?
3. Would there be any segments of the community for which these programs/services may appear inaccessible?
 - a. For example undocumented, monolingual Spanish speakers, or older/younger women?
 - b. Probe: do they serve all immigrant Mexican women equally?
4. Do these efforts focus on increasing awareness about the importance of cancer screening?
 - a. Do they focus on informing women where to receive these services?
5. Do the programs you identified earlier differ from the programs/services in other communities? In what ways?
6. Using a scale from 1-10, how much of a concern is increasing awareness about the importance of BC screening among women in the community?

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

“Not at all”

“A very great concern”

- a. Can you please explain?

7. Using a scale from 1-10, how much of a concern is increasing awareness about the importance of CC screening among women in the community?

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

“Not at all”

“A very great concern”

- a. Can you please explain?

8. How knowledgeable are women about where to seek BC and CC screening services?
 - a. Probe: About where to find low cost or free services?
9. Is there any planning for additional efforts and services regarding cancer screening exams in the community?
 - a. If yes, please explain.

LEADERSHIP

1. Who are the leaders (individuals and/or organizations) involved with cancer screening efforts in Little Village?

2. To what extent are appointed leaders and influential community members supportive of the efforts to increase cancer screening in the community?
3. Would the leadership support additional efforts?
 - a. Please explain.
4. Which institutions/organizations in the community do you feel are big players in establishing and maintaining screening programs and services?
 - a. For example, churches, health care facilities, schools, and other community outlets?
 - b. Please explain your answer?
5. Does the leadership in the community make screening efforts (including programs, services, and outreach) unique from those found in other Latino/immigrant communities?
 - a. Please explain.

Please remember that the types of cancer and screening exams I am referring to are breast and cervical, and “women” refers to Mexican immigrant women living in Little Village community.

COMMUNITY CLIMATE

1. How does Little Village support the efforts to address BC screening?
 - a. What about the efforts to address CC screening?
2. What are the main obstacles to efforts addressing programs/services on BC screening in the community?
 - a. What about the main obstacles for addressing programs/services on CC screening?
3. Based on the answers you have provided so far, what do you believe are the general feelings of members of the community around this issue?
4. Compared to other health issues (e.g., diabetes, heart problems, etc.) to what extent is cancer screening a priority in the community?
 - a. Probe: Are there more or less programs or services that address cancer screening?
 - b. Probe: Is there more or less funding for programs or services around cancer screening?
5. For women who need to obtain these screening exams, what are the biggest barriers to access these programs and services in the community?

Probe:

 - a. Cost
 - b. Transportation
 - c. Language barriers
 - d. Information about the importance of cancer screening
 - e. Trouble finding child care

- f. Trouble navigating the local health care system
 - g. Another barrier that has not been mentioned?
6. What do you feel are the biggest facilitative factors to access screening services in the community?
- Probe:
- a. Low cost/free services
 - b. Health care providers located in Little Village
 - c. Bilingual health care providers
 - d. Information about the importance of cancer screening
 - e. Help navigating the local health care system
 - f. Another factor that has not been mentioned?

COMMUNITY KNOWLEDGE ABOUT THE ISSUE

1. How knowledgeable are women living in Little Village about the importance of BC and screening exams?
 - a. Probe: When to get a mammogram
 - b. Probe: BC risk factors, causes, and treatment
2. How knowledgeable are women living in the community about CC and screening exams?
 - a. Probe: When to get a Pap smear
 - b. Probe: CC risk factors, causes, and treatment?
3. What type of information is available to women in the community about cancer and the importance of early detection?
 - a. Is this information easily accessible?
 - b. Is the information trustworthy?
 - c. Is the information available in Spanish?
4. What are the main avenues by which women obtain information about cancer and screening exams in the community?
 - a. Probe: Family member, friend, health care professional or other community organization?
 - b. Who (individual or organization) is the most trusted source to give this type of information?
 - c. How do you think that the process of obtaining information is different for Mexican immigrant women than for other women?
5. To what extent is there media coverage in Spanish of cancer and the importance of early detection in the community?
 - a. For example, in the newspapers, television, radio, and the internet?

RESOURCES FOR THE EFFORTS RELATED TO EARLY DETECTION

1. To whom or where would women needing cancer screenings turn to first for help in Little Village?
 - a. Why?
2. What is the community's attitude about supporting efforts around screening with people volunteering time, making financial donations, and/or providing space?
3. How are the current efforts funded?
 - a. Please explain.
4. Are you aware of any proposals or action plans that have been submitted for funding to address screening in the community?
 - a. If yes, please explain.
5. Do you know if there is any evaluation of these efforts?
 - a. If yes, using a scale from 1 to 10, how sophisticated is the evaluation effort?

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

“Not at all”

“Very sophisticated”

6. Are the evaluation results being used to make changes in programs, activities, or policies or to start new ones?

In 2006, I conducted a small study of Mexican immigrant women living in Little Village. Of the women who participated in the study, 87% reported having had a mammography screening and 95% Pap smear screening exam. Are there any other factors that can account for this that we have not already discussed?

That's all the questions.

Thank you so much for your time.

Spanish Version

Influencias Comunitarias en los Exámenes de Detección de Cáncer en Mujeres Inmigrantes Mexicanas

El “Community Readiness Assesment (CRA) fue adaptado de su versión original creada por el Tri-Ethnic Center for Prevention Research en la Universidad del Estado de Colorado.

PREGUNTAS ACERCA DE SI MISMO/A

1. ¿Cuál es su edad? _____
2. ¿Cuál es su etnia? _____
3. ¿Cuál es su posición? _____
4. ¿Cuánto tiempo tiene en esta posición? _____
5. ¿Cuál es la demografía de la población a la que esta organización sirve?
 - a. Inmigrantes de México: _____
 - b. Puerto Rico: _____
 - c. Otros: _____
6. ¿Cuánto tiempo ha estado Usted involucrado/a con la comunidad Latina en general?
7. ¿Cuánto tiempo ha estado Usted involucrado/a con la comunidad en La Villita?

Para las siguientes preguntas en la entrevista, la palabra comunidad se refiere a La Villita y la población en la que estoy interesada son en las mujeres Mexicanas inmigrantes.

ESFUERZOS DE LA COMUNIDAD Y EL CONOCIMIENTO ACERCA DE LA DETECCION DEL CANCER

1. Por favor describa los programas y servicios disponibles en La Villita dirigidos a incrementar el conocimiento sobre la importancia de la detección temprana del cáncer del seno y sobre la mamografía.
 - a. ¿A quiénes proveen servicios estos programas?
 - b. ¿Quién es responsable por ofrecer estos programas/servicios?
 - c. ¿Por cuánto tiempo han estado en pie estos esfuerzos en su comunidad?
 - d. ¿Cree usted que hay necesidad de expandir estos esfuerzos/servicios?
 - e. ¿Cuáles son los puntos fuertes (las fortalezas) de estos esfuerzos?
 - f. ¿Cuáles son los puntos débiles (las debilidades) de estos esfuerzos?
2. Por favor describa los programas y servicios disponibles en la comunidad dirigidos a incrementar el conocimiento sobre la importancia de la detección temprana del cáncer del cuello uterino y sobre el Papanicolau.
 - a. ¿A quiénes proveen servicios estos programas?

- b. ¿Quién es responsable por ofrecer estos programas/servicios?
 - c. ¿Por cuánto tiempo han estado en pie estos esfuerzos en su comunidad?
 - d. ¿Cree usted que hay necesidad de expandir estos esfuerzos/servicios?
 - e. ¿Cuáles son los puntos fuertes (las fortalezas) de estos esfuerzos?
 - f. ¿Cuáles son los puntos débiles (las debilidades) de estos esfuerzos?
3. ¿Habrían segmentos de la comunidad para los que estos programas y servicios puedan parecer inaccesibles?
- a. ¿Por ejemplo, mujeres indocumentadas, que solo hablan español, mujeres jóvenes o mujeres mayores?
 - b. ¿Estos programas proveen servicios para todas las mujeres inmigrantes por igual?
4. ¿Estos esfuerzos se enfocan a incrementar el conocimiento de las mujeres acerca de la importancia de los exámenes de detección del cáncer?
- a. ¿Estos se enfocan en informar a mujeres adónde pueden obtener estos servicios?
5. ¿De los programas que identificó anteriormente son diferentes que los programas/servicios que existen en otras comunidades? ¿De qué manera?
6. Usando una escala del 1-10, ¿qué tan importante es el incrementar el conocimiento acerca de la importancia de los exámenes de detección del cáncer del seno en mujeres de la comunidad?

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

“Para nada”
importante”

“Muy

- a. ¿Por favor explique?

7. Usando una escala del 1-10, ¿qué tan importante es incrementar en conocimiento acerca de la importancia de los exámenes de detección del cáncer del cuello uterino en mujeres de la comunidad?

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

“Para nada”
importante”

“Muy

- a. ¿Por favor explique?

8. ¿Qué tanto conocimiento tienen las mujeres acerca de lugares donde pueden obtener los exámenes de detección de cáncer?

- a. Pregunta: ¿Acerca de lugares que proveen servicios gratuitos o a bajo costo?

9. ¿Hay en la actualidad planes adicionales para desarrollar esfuerzos y servicios relacionados a los exámenes de detección del cáncer en la comunidad?

- a. Si es afirmativo, por favor explique

LIDERAZGO

1. ¿Quiénes son los “líderes” (personas u organizaciones) que trabajan para promover los exámenes de detección del cáncer del seno y del cuello uterino en La Villita?
2. ¿Hasta qué punto estos líderes u otros miembros influyentes de la comunidad apoyan los esfuerzos para que mujeres se hagan los exámenes de cáncer en la comunidad?
3. ¿Usted cree que el liderazgo apoyaría esfuerzos adicionales?
 - a. Por favor explique.
4. ¿Cuáles son las instituciones y organizaciones principales en la comunidad que establecen y mantienen los programas y servicios relacionados con los exámenes de detección del cáncer del seno y del cuello uterino?
 - a. Por ejemplo, ¿iglesias, instituciones de la salud, escuelas, y otros sitios comunitarios?
 - b. Por favor explique.
5. ¿El liderazgo de la comunidad hace que los programas, servicios, y el alcance comunitario relacionados con el cáncer del seno y del cuello uterino se destaquen de los esfuerzos en otras comunidades Latinas inmigrantes?
 - a. Por favor explique.

Por favor recuerde que los tipos de cáncer y exámenes de detección a los que me refiero son del seno y el cuello uterino y “mujeres” se refieren a mujeres inmigrantes Mexicanas que viven en La Villita.

CLIMA DE LA COMUNIDAD

1. ¿De qué manera apoya la comunidad a los esfuerzos para promover los exámenes de cáncer del seno?
 - a. ¿De qué manera apoya la comunidad a los esfuerzos de promover exámenes de cáncer del cuello uterino?
2. ¿Cuáles son los obstáculos principales a los esfuerzos para abordar los programas/servicios de los exámenes cáncer del seno en la comunidad?
 - a. ¿Cuáles son los mayores obstáculos para los esfuerzos a los programas/servicios de los exámenes del cáncer del cuello uterino?
3. Basado en las respuestas que ha proporcionado hasta ahora, ¿cuál cree que es el sentimiento general de los miembros de la comunidad acerca de este tema?
4. Comparado a otros problemas de salud (por ejemplo, la diabetes, problemas del corazón, etc.) ¿qué prioridad tienen los exámenes de detección de cáncer?
 - a. Pregunta: ¿Hay más o menos programas o servicios enfocados en la detección del cáncer?
 - b. Pregunta: ¿Hay may o menos fondos para los programas o servicios enfocados a los exámenes de detección del cáncer?

5. Para mujeres que necesitan obtener estos exámenes de detección, ¿cuáles son las mayores barreras que previenen que mujeres tengan acceso a estos programas y servicios en la comunidad?
- Pregunta:
- a. Costo
 - b. Transporte
 - c. Problemas con el idioma
 - d. Falta de información acerca de la importancia de los exámenes de detección del cáncer
 - e. Cuidado de sus hijos/hijas
 - f. Dificultades al acceder a los servicios de salud locales, como por ejemplo al hacer una cita
 - g. ¿Alguna otra barrera que no haya sido mencionada?
6. ¿Qué factores principales piensa usted que facilitan el acceso a los exámenes de detección en la comunidad?
- a. Bajo costo/servicios gratis
 - b. Proveedores de salud localizados en la Villita
 - c. Proveedores de salud bilingües
 - d. Información acerca de los exámenes de detección del cáncer
 - e. Facilidad de acceder al los servicios de salud locales
 - f. ¿Algún otro factor que no haya mencionado?

CONOCIMIENTO DE LA COMUNIDAD SOBRE EL TEMA

1. ¿Qué tanto saben las mujeres en La Villita acerca del cáncer del seno y de la importancia de hacerse la mamografía?
 - a. Pregunta: ¿Acerca de cuándo hacerse la mamografía?
 - b. Pregunta: ¿Acerca de los riesgos, causas, y tratamiento para el cáncer del seno?
2. ¿Qué tanto saben las mujeres en la comunidad acerca del cáncer del cuello uterino y de la importancia de hacerse el Papanicolaou?
 - a. Pregunta: ¿Acerca de cuándo hacerse el Papanicolaou?
 - b. Pregunta: ¿Acerca de los riesgos, causas, y tratamiento para el cáncer del cuello uterino?
3. ¿Qué tipo de información está disponible para mujeres en la comunidad acerca de la importancia de los exámenes de detección del cáncer?
 - a. ¿Esta información es fácil de obtener?
 - b. ¿Esta información es creíble?
 - c. ¿Esta información está disponible en Español?
4. ¿Cómo obtienen esta información?
 - a. Pregunta: ¿Por medio de parientes, amigos/as, personas que proveen servicios médicos, o por una organización de la comunidad?
 - b. ¿Quién (persona u organización) es la fuente de más confianza para dar este tipo de información?

- c. ¿Piensa que el proceso de obtener información es diferente para mujeres inmigrantes Mexicanas que para otras mujeres? ¿De qué manera?
5. ¿Qué tanta cobertura hay en los medios de comunicación en Español sobre el cáncer del seno o del cuello uterino y sobre la importancia de la detección temprana?
 - a. ¿Por ejemplo, en los periódicos, televisión, radio, y la internet?

RECURSOS PARA LOS ESFUERZOS RELACIONADOS CON LA DETECCION TEMPRANA

1. ¿A quien o adónde acudirían primero mujeres que necesiten ayuda obteniendo un examen de detección del cáncer en La Villita?
 - a. ¿Por qué?
2. ¿Cuál es la actitud de la comunidad acerca de apoyar los esfuerzos? Por ejemplo, hay voluntarios que ofrecen su tiempo, gente u organizaciones que hacen donaciones monetarias o que proveen espacio?
3. ¿De qué manera se están financiando estos esfuerzos en la actualidad?
 - a. Si es afirmativo, por favor explique.
4. ¿Usted sabe si hay propuestas o planes de acción que han sido sometidos para obtener fondos para abordar el tema de los exámenes del cáncer en la comunidad?
 - a. Por favor explique.
5. ¿Usted sabe si hay planes para evaluar los esfuerzos existentes para abordar este tema?
 - a. Si es afirmativo, en una escala del 1 al 10, ¿qué tan sofisticada es la evaluación?

1	2	3	4	5	6	7	8	9	10
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“No lo es”

“Muy sofisticada”

6. ¿Se están usando los resultados de la evaluación para hacer cambios o para empezar nuevos programas, actividades y políticas?

En el 2006, yo hice un estudio pequeño sobre la participación de las mujeres inmigrantes mexicanas viviendo en la Villita. De las mujeres que participaron en el estudio, 87% reportaron haber recibido una mamografía, y 95% reportaron haberse hecho el Papanicolaou. ¿Existen otros factores que pueden explicar esto que no hemos discutido ya?

Esas son todas las preguntas.

Muchísimas gracias por su tiempo y amable colaboración.

APPENDIX D

Informed Consent Forms

Phase I

Informed Consent: English Version

INFORMED CONSENT LETTER

Thank you for your interest in this study. You are invited to participate in a research project about Latina's healthcare practices in Chicago. This project will be conducted by Yadira Montoya and Professor Lydia P. Buki from the Department of Educational Psychology at the University of Illinois at Urbana-Champaign.

In this project, you will be asked you to complete a questionnaire about your knowledge, beliefs, and experiences in obtaining breast and cervical cancer screenings.

Your participation in this study is strictly voluntary. If you decide to participate, please fill out this questionnaire, which includes questions about health screenings and access to healthcare. The questionnaire will take about twenty minutes to complete and data collected will be secure and kept locked in Dr. Buki's research lab. The results from this study will only be accessible only to project personnel.

Your answers will be anonymous, therefore you do not need to include your name or other identifying information on these pages. You may refuse to participate, or refuse to answer any question(s) that make you feel uncomfortable, without penalty or loss of benefits.

If you have any questions about this project, please contact Yadira Montoya by telephone at 217-260-7861 or by email ymontoya@uiuc.edu or Professor Lydia P. Buki at 217-265-5491 or buki@uiuc.edu. Thank you very much for your time and consideration.

Sincerely,

Yadira Montoya

Informed Consent: Spanish Version

CARTA DE CONSENTIMIENTO

Muchas gracias por su interés en participar en este estudio. La invitamos a participar en este proyecto sobre las prácticas de salud de mujeres Latinas en Chicago. Este proyecto va a ser conducido por Yadira Montoya y la Profesora Lydia P. Buki de la Universidad de Illinois en Urbana-Champaign.

En este proyecto, le vamos a pedir que llene un cuestionario sobre sus conocimientos, creencias, y experiencias en obtener exámenes de la cervix y la mamografía.

Su participación en esta investigación es estrictamente voluntaria. Si decide participar, por favor llene esta encuesta, la cual hace preguntas acerca de exámenes de salud y acceso a servicios médicos. El cuestionario le tomará aproximadamente veinte minutos para completar. Los resultados serán guardados bajo llave en la oficina de la Dra. Buki. La información que se obtenga por medio del cuestionario será compartida con otros profesionales en presentaciones o en publicaciones profesionales.

Sus respuestas serán anónimas, y no necesitamos que indique su nombre u otra información que la pueda identificar en estas hojas. Ud. tiene la libertad de no participar, o de no contestar cualquier pregunta(s) que la incomode sin ninguna pérdida de beneficios que pueda acceder ahora.

Si tiene alguna pregunta acerca de este proyecto, por favor contacte a Yadira Montoya al 217-260-7861 o ymontoya@uiuc.edu, o a Lydia P. Buki, Ph.D., profesora en la Universidad de Illinois, al 217-265-5491 o buki@uiuc.edu. Se le agradece por su tiempo y amable consideración.

Sinceramente,

Yadira Montoya

Phase II

Informed Consent: English Version

UNIVERSITY OF ILLINOIS AT URBANA CHAMPAIGN INFORMED CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

TITLE OF PROJECT: Community influences on cancer screening behaviors among Mexican immigrants.

NAME OF LEAD INVESTIGATOR: Yadira Montoya, B.S.

NAME OF PRINCIPAL INVESTIGATOR: Lydia P. Buki, Ph.D.

CONTACT NAME AND PHONE NUMBER FOR QUESTIONS/PROBLEMS: Yadira Montoya, B.S. at (217) 260-7861 or via email (ymontoya@illinois.edu) or Lydia P. Buki, Ph.D. at (217) 265-5491 or via email (buki@illinois.edu).

PURPOSE OF THE RESEARCH: The purpose of this study is to obtain information about the community factors that influence breast and cervical cancer screening among Mexican immigrant women living in Little Village. I am interested in the information, resources, and screening exams available to women living in the community. Your responses may provide insight into the types of programs and services that promote Mexican women's health.

PROCEDURES/METHODS TO BE USED: I will be conducting individual interviews with key community leaders about the factors present in Little Village that may enable or discourage women in the community to access breast and cervical cancer screening programs and services. One meeting will take place and it should last approximately 60-90 minutes. In the meeting, I will be asking you a series of questions on the topic and may take written notes on some of the responses. This meeting may also be audiotaped with your permission to ensure that none of the information you provide is lost. However, only your first name will be used in the interview, and your name and the organization's name will not be included on any written materials. The tape recordings and notes will be destroyed when the study is finished.

RISKS INHERENT IN THE PROCEDURES: You have the right to refuse to answer a question or to discontinue participation at any time without any penalty or loss of benefits to which you are otherwise entitled. In addition, discontinuing participation or choosing not to answer a question will have no impact on any aspect of your future relations with the University of Illinois. Although it is not possible to identify all potential risks in research procedures, the researchers have taken reasonable safeguards to minimize any known risks. The risks are not expected to be beyond those you encounter when talking about this topic in your daily life.

BENEFITS: Your participation will help us gain more information on the needs and gaps in the community around issues of education, awareness, and the actual availability of breast and cervical cancer screenings. In the process of answering the different questions in the interview you may think about the programs and services that are available in Little Village community. I

can also provide you with a copy of the study's findings that will include information on the community efforts around promoting cancer screening services.

CONFIDENTIALITY: Only your first name will be used in the interview and once the study is finished, the tapes will be destroyed. I will not use your name or the name of the organization when discussing or reporting the study findings.

CONTACT INFORMATION: If at any time you have a question about your participation in this study, you may ask me or you may contact the principal investigator, Dr. Lydia P. Buki, at (217) 265-5491 or via email (buki@illinois.edu). If you have any questions about your rights as a participant in this study, please contact the University of Illinois Institutional Review Board at (217) 333-2670 (collect calls accepted if you identify yourself as a research participant) or via email at irb@illinois.edu. They can provide more information about the participation and well being of people who participate in these types of studies. You may call these numbers collect if you live outside the calling area.

PARTICIPATION: Your participation in this research is strictly voluntary. If you decide to participate in the study, you may withdraw your consent and stop participating at any time without penalty or loss of benefits to which you are otherwise entitled. Your signature acknowledges that you have read the information stated and that you voluntarily agree to take part in this project and to have the interview audiotaped. Your signature also acknowledges that you have been offered, on the date signed, a copy of this document containing two pages.

I give permission for the interview to be tape recorded: ☐ Yes ☐ No

Participant printed name

Signature

Date

Informed Consent: Spanish Version

UNIVERSIDAD DE ILLINOIS EN URBANA CHAMPAIGN INFORMACIÓN PARA CONSENTIR A PARTICIPAR EN UN PROYECTO DE INVESTIGACIÓN

TÍTULO DEL PROYECTO: Influencias comunitarias en las tasas de los exámenes de detección en mujeres inmigrantes Mexicanas.

NOMBRE DE LA INVESTIGADORA: Yadira Montoya, B.S.

NOMBRE DE LA INVESTIGADORA RESPONSABLE: Lydia P. Buki, Ph.D.

NOMBRE Y TELÉFONO DE LA PERSONA A CONTACTAR EN CASO

DEPREGUNTAS Y/O PROBLEMAS: Yadira Montoya, B.S., al (217) 260-7861 o por correo electrónico (ymontoya@illinois.edu) o Lydia P. Buki, Ph.D. al (217) 265-5491 o por correo electrónico (buki@illinois.edu).

PROPÓSITO DEL PROYECTO: El propósito de este proyecto es obtener información acerca de los factores comunitarios que contribuyen a la participación en exámenes de cáncer del seno y del cuello uterino en mujeres inmigrantes Mexicanas que viven en La Villita. Estoy interesada la información, recursos, y exámenes de detección disponibles para mujeres que viven en la comunidad. Esperamos que sus respuestas nos ayuden a comprender el tipo de programas y servicios que promueven la salud de mujeres Mexicanas.

PROCEDIMIENTOS/MÉTODOS QUE SE UTILIZARÁN: Yo haré entrevistas individuales con miembros de la comunidad sobre los factores presentes en La Villita que impiden o facilitan que mujeres en la comunidad tengan acceso a información sobre los exámenes de detección del cáncer. Vamos a reunirnos una vez por aproximadamente 60-90 minutos. En la reunión, yo le haré una serie de preguntas acerca del tema y tomaré notas de sus respuestas. Esta reunión podrá ser grabada con su permiso para asegurarme que no se pierda ninguna información que usted provea. Sin embargo, durante la entrevista sólo su primer nombre será utilizado, y su nombre o el nombre de la organización no serán incluidos en ningún material escrito. Los casetes y las notas serán destruidos cuando el estudio concluya.

RIESGOS INVOLUCRADOS EN LOS PROCEDIMIENTOS: Usted tiene el derecho de negarse a responder cualquier pregunta o de discontinuar su participación en cualquier momento sin riesgo de ser penalizada o de perder los beneficios para los que es elegible. Asimismo, si discontinúa su participación o se niega a responder cualquier pregunta, esto no tendrá impacto sobre ningún aspecto de sus relaciones futuras con la Universidad de Illinois. Aunque no es posible identificar todos los riesgos potenciales en los procedimientos de investigación, la(s) investigadora(s) ha(n) tomado precauciones para minimizar cualquier tipo de riesgo conocido. No esperamos que estos riesgos sean más allá de lo que Usted se encuentre hablando de este tema en su vida diaria.

BENEFICIOS: Su participación en esta entrevista ayudará a obtener más información sobre las necesidades relacionadas con la educación, conocimiento, y la disponibilidad de exámenes de detección del cáncer de seno y del cuello del útero. El contestar las diferentes preguntas en la entrevista podrá ayudarle a refeccionar sobre los diferentes programas y servicios disponibles en La Villita. Yo también le puedo dar una copia de los resultados del estudio, los cuales incluirán información acerca de los esfuerzos comunitarios relacionados con la promoción de exámenes de detección del cáncer.

CONFIDENCIALIDAD: Sólo se usará su primer nombre en la entrevista. Cuando el estudio finalice, los casetes y las notas serán destruidos. No usaré su nombre o el nombre de la organización cuando reporte los resultados del estudio.

INFORMACIÓN DE LOS CONTACTOS DE ESTE ESTUDIO: Si en cualquier momento usted tuviera alguna(s) pregunta(s) acerca de su participación en este estudio, usted puede preguntarme a mí durante la entrevista o puede contactar a la investigadora responsable, Dra. Lydia P. Buki, al teléfono (217) 265-5491 o por correo electrónico (buki@illinois.edu). Si usted tiene preguntas sobre sus derechos como participante de esta investigación, favor de contactar la oficina del Institutional Review Board de la Universidad de Illinois en Urbana-Champaign al (217) 333-2670 o por correo electrónico (irb@illinois.edu). Si usted vive fuera del área de llamadas locales, puede solicitar el pago revertido de su llamada.

PARTICIPACIÓN: Su participación en este estudio es estrictamente voluntaria. Si decide participar en el estudio usted puede retirar su consentimiento y negar su participación en el mismo en cualquier momento sin riesgo de ser penalizada o de perder los beneficios que le corresponden. Su firma indica que usted ha leído esta información, que de su propia voluntad acepta participar en este proyecto, y que acepta que la entrevista sea grabada. Su firma también indica que en el día de la fecha se le ha ofrecido una copia de esta forma que contiene dos páginas.

Yo doy permiso para que la entrevista sea grabada: ☐ Si ☐ No

Nombre del participante (en imprenta)	Firma	Fecha
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